INQUIRY MENU

DIRECT DATA ENTRY (DDE) MANUAL

CHAPTER 3

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Inquiry Menu Options

The Inquiries option (FISS Main Menu option 01) allows you to:

- Check the status of submitted billing transactions
- Locate claims in an ADR (Additional Development Request) status
- View a summary of all claims currently being processed in the system
- Verify revenue codes, diagnosis codes, HCPCS codes, adjustment reason codes, reason codes, and ANSI (American National Standards Institute) codes
- View the amount and payment date of the last three checks issued to your facility

Access the Inquiry Menu

1. From the FISS Main Menu (Map 1701), type 01 in the **Enter Menu Selection** field and press ***Enter***.

```
MAP1701                  CGS J15 MAC - Part A REGION           ACPFA052
MM/DD/YY
XXXXXX                          MAIN MENU                  C20112WS HH:MM:SS

                        01    INQUIRIES

                        02    CLAIMS/ATTACHMENTS

                        03    CLAIMS CORRECTION

                        04    ONLINE REPORTS


  ENTER MENU SELECTION: 01

   PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

2. The Inquiry Menu (Map 1702) appears:

```
MAP1702                  CGS J15 MAC - Part A REGION        ACPFA052 MM/DD/YY
XXXXXX                       INQUIRY MENU                C20112WS HH:MM:SS


        BENEFICIARY/CWF          10    ZIP CODE FILE            19

        DRG (PRICER/GROUPER)     11    OSC REPOSITORY INQUIRY   1A

        CLAIM SUMMARY            12    CLAIM COUNT SUMMARY      56

        REVENUE CODES            13    HOME HEALTH PYMT TOTALS  67

        HCPC CODES               14    ANSI REASON CODES        68

        DX/PROC CODES ICD-9      15    CHECK HISTORY            FI

        ADJUSTMENT REASON CODES  16    DX/PROC CODES ICD-10     1B

        REASON CODES             17

     ENTER MENU SELECTION:


      PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

Enter the two-characters for the inquiry option you want to access and press Enter. All of the options are described in this chapter.

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- All of the options are represented by two numerals, except for OSC Repository Inquiry (1A), and Check History (FI), and Dx/Proc Codes ICD-10 (1B).
- All FISS direct data entry (DDE) screens display two lines of information in the top right corner that identifies the region (ACPFA052), the current date, release number (e.g., C20112WS) and the time of day. This information is for internal purposes only and is used to assist CGS staff in researching issues when screen prints are provided.

Beneficiary/CWF (Option 10)

This option is helpful **only** if you need to view the beneficiary's address. The beneficiary's address is not available on the CWF (Common Working File) eligibility screens, ELGA and ELGH, but is available by using this option.

1. From the Inquiry Menu, type 10 in the **Enter Menu Selection** field and press Enter.

```
MAP1702                  CGS J15 MAC - Part A REGION       ACPFA052 MM/DD/YY
XXXXXX                INQUIRY MENU                        C20112WS HH:MM:SS


        BENEFICIARY/CWF          10    ZIP CODE FILE             19

        DRG (PRICER/GROUPER)     11    OSC REPOSITORY INQUIRY    1A

        CLAIM SUMMARY            12    CLAIM COUNT SUMMARY       56

        REVENUE CODES            13    HOME HEALTH PYMT TOTALS   67

        HCPC CODES               14    ANSI REASON CODES         68

        DX/PROC CODES ICD-9      15    CHECK HISTORY             FI

        ADJUSTMENT REASON CODES  16    DX/PROC CODES ICD-10      1B

        REASON CODES             17

     ENTER MENU SELECTION:  10


      PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

- Although, this option includes several screen pages with eligibility information, only screen examples and field descriptions for the first screen page are explained below. **The remaining screen pages should not be used to verify Medicare eligibility because it may not be as current as the CWF information that you access via ELGA.** For information about accessing ELGA, refer to Chapter 2 of this guide.
- You may also access this screen by typing ***10*** in the **SC** field if you are in an inquiry or claim entry screen.

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2. The Eligibility Detail Inquiry screen (Map 1751) appears:

```
MAP1751                  CGS J15 MAC - Part A REGION          ACPFA052
MM/DD/YY
XXXXXX   SC              ELIGIBILITY DETAIL INQUIRY        C20112WS HH:MM:SS

 HIC              CURR XREF HIC                PREV XREF HIC
 TRANSFER HIC                C-IND      LTR DAYS
 LN                    FN                  MI     SEX
 DOB           DOD
 ADDRESS: 1                                2
          3                                4
          5                                6
      ZIP:

                       CURRENT ENTITLEMENT
 PART A EFF DT       TERM DT        PART B EFF DT          TERM DT

  CURRENT                BENEFIT PERIOD DATA
 FRST BILL DT          LST BILL DT          HSP FULL DAYS   HSP PART DAYS
 SNF FULL DAYS    SNF PART DAYS     INP DED REMAIN          BLD DED PNTS

                          PSYCHIATRIC
 PSY DAYS REMAIN     PRE PHY DAYS USED      PSY DIS DT        INTRM DT IND

    PLEASE ENTER DATA - HIC, LN, FN, SEX, AND DOB.
          PRESS PF3-EXIT  PF8-NEXT PAGE
```

3. As indicated at the bottom of the Map 1751, you must have the following five pieces of information about the beneficiary to access information:

   HICN (Health Insurance Claim Number) (also called their Medicare number)
   Last Name
   First Name
   Gender
   Date of Birth (MMDDCCYY format)

   You can use the following function keys to move around the screens:

   F3 – Exit (return to the Inquiry Menu)
   F7 – Move one page back
   F8 – Move one page forward

4. Start by entering the beneficiary's HICN as it appears on their Medicare card in the **HIC** field.
5. Tab to the **LN** field. Type the beneficiary's last name as it appears on their Medicare card.
6. Tab to the **FN** field. Type the beneficiary's first name as it appears on their Medicare card.
7. Tab to the **SEX** field. Type the gender of the beneficiary. M = male; F = female
8. The cursor will automatically move to the **DOB** field. Type the beneficiary's date of birth (MMDDCCYY) and press ***Enter***.
9. The following example shows how the screen would look after entering the five identifying pieces of information, but before pressing ***Enter***.

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```
MAP1751                    CGS J15 MAC - Part A REGION        ACPFA052 MM/DD/YY
XXXXXX   SC          ELIGIBILITY DETAIL INQUIRY             C20112WS HH:MM:SS

 HIC 123456789A     CURR XREF HIC                PREV XREF HIC
 TRANSFER HIC                  C-IND     LTR DAYS
 LN SMITH               FN JOHN              MI     SEX  M
 DOB 01011931  DOD
 ADDRESS: 1                                  2
          3                                  4
          5                                  6
      ZIP:

                        CURRENT ENTITLEMENT
 PART A EFF DT       TERM DT         PART B EFF DT       TERM DT

  CURRENT               BENEFIT PERIOD DATA
 FRST BILL DT        LST BILL DT          HSP FULL DAYS      HSP PART DAYS
 SNF FULL DAYS   SNF PART DAYS      INP DED REMAIN             BLD DED PNTS

                            PSYCHIATRIC
 PSY DAYS REMAIN       PRE PHY DAYS USED    PSY DIS DT          INTRM DT IND

     PLEASE ENTER DATA - HIC, LN, FN, SEX, AND DOB.
           PRESS PF3-EXIT   PF8-NEXT PAGE
```

9. After you press ***Enter***, the system will search for the beneficiary's eligibility file. If a match is found, additional information will display on Map 1751. If no match is found, verify that you have entered the correct information, make any necessary corrections, and press ***Enter*** again.
   - Information will only display if CGS has processed a claim for the beneficiary. If no match is found, a claim for the beneficiary has not been submitted/processed in FISS by CGS.
   - Do not use this option to verify Medicare eligibility because it may not be as current as the CWF (Common Working File) information that you access via ELGA or myCGS. Use option 10 only if you need information about the beneficiary's addressChapter 2 of this guide for information about accessing beneficiary eligibility information.
10. Once a match is found with the beneficiary information entered, the beneficiary's home address will appear in the ADDRESS and ZIP fields.
11. Press ***F3*** to exit and return to the Inquiry Menu.

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Field Descriptions for Option 10 - Beneficiary/CWF Screen

Map 1751 (Page 1) Screen Example

```
MAP1751                      CGS J15 MAC - Part A REGION          ACPFA052 MM/DD/YY
XXXXXX   SC                ELIGIBILITY DETAIL INQUIRY           C20112WS HH:MM:SS

 HIC                  CURR XREF HIC                 PREV XREF HIC
 TRANSFER HIC                      C-IND      LTR DAYS
 LN                        FN                    MI     SEX
 DOB            DOD
 ADDRESS: 1                                     2
          3                                     4
          5                                     6
      ZIP:

                           CURRENT ENTITLEMENT
 PART A EFF DT          TERM DT          PART B EFF DT          TERM DT

  CURRENT                  BENEFIT PERIOD DATA
 FRST BILL DT           LST BILL DT          HSP FULL DAYS     HSP PART DAYS
 SNF FULL DAYS      SNF PART DAYS      INP DED REMAIN            BLD DED PNTS

                           PSYCHIATRIC
 PSY DAYS REMAIN       PRE PHY DAYS USED       PSY DIS DT          INTRM DT IND

     PLEASE ENTER DATA - HIC, LN, FN, SEX, AND DOB.
           PRESS PF3-EXIT   PF8-NEXT PAGE
```

Map 1751 Field Descriptions	
HIC	The beneficiary's HICN (Health Insurance Claim Number).
LN	Last name of the beneficiary.
FN	First name of the beneficiary.
MI	Middle initial of the beneficiary.
SEX	Sex of the beneficiary. **F** Female **M** Male
DOB	Date of birth of the beneficiary (MMDDCCYY format).
DOD	Date of death of the beneficiary (MMDDCCYY format).
ADDRESS (1-6)	Beneficiary's street address, city and state.
ZIP	Zip code for beneficiary's residence.

The remaining field descriptions are not provided as you should not use the information to verify Medicare eligibility because it may not be as current as the CWF (Common Working File) information that you access via ELGA. Refer to Chapter 2 of this guide for information about accessing beneficiary information using ELGA or myCGS.

DRG Pricer/Grouper (Option 11)

This option allows you to view specific DRG (diagnostic related group) assignment and PPS (prospective payment system) information for inpatient hospital stays as calculated by the Pricer/Grouper software programs within FISS. Because this information is typically used only by hospitals, and this guide provides information relevant only to home health and hospice agencies, the information below is limited, and shows only how this option is accessed.

1. From the Inquiry Menu, type ***11*** in the **Enter Menu Selection** field and press Enter.
   - You may also access this screen by typing ***11*** in the **SC** field if you are in an inquiry or claim entry screen.

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2. The DRG/PPS Inquiry screen (Map 1781) appears:

```
MAP1781                  CGS J15 MAC - Part A REGION       ACPFA052 MM/DD/YY
  XXXXXX    SC              DRG/PPS INQUIRY              C20112WS HH:MM:SS
 DIAGNOSES:   1         2          3            4        5
              6         7          8            9        POA
 PROCEDURES:  1         2          3            4        5
              6         7          8            9        NPI
  SEX      C-I   DISCHARGE STATUS          DT          PROV
  REVIEW CODE    TOTAL CHARGES             DOB         OR AGE
  APPROVED LOS   COV DAYS                  LTR DAYS    PAT LIAB
  RETURNED FROM GROUPER:                              GROUPER VERSION
     D.R.G.                  MAJOR DIAG CAT           RETURN CODE
     PROC CD USED            DIAG CD USED             SEC DIAG USED
  RETURNED FROM PRICER:                               PRICER VERSION
     RTN CD     WAGE INDEX              OUTLIER DAYS
     AVG# LENGTH OF STAY                OUTLIER DAYS THRESHOLD
     OUTLIER COST THRES                 INDIRECT TEACHING ADJ#
     TOTAL BLENDED PAYMENT              HOSPITAL SPECIFIC PORTION
     FEDERAL SPECIFIC PORTION           DISP# SHARE HOSPITAL AMT
     PASS THRU PER DISCHARGE            OUTLIER PORTION
     PTPD + TEP                         STANDARD DAYS USED
     LTR DAYS USED                      PROV REIMB

          PLEASE ENTER DATA, PF3-EXIT, PF6-FWD, PF8-COST DISCLOSURE, ENTER-PROCESS
```

Claims (Option 12)

You will use this option often because it allows access to a variety of claim processing information. The following provides instructions on how to:

- Check the status of your billing transactions / beneficiary claim history
- Check for Additional Development Requests (ADRs)
- View line item denial information

1. From the Inquiry Menu, type ***12*** in the **Enter Menu Selection** field and press ***Enter***.

```
  MAP1702                      CGS J15 MAC - Part A REGION   ACPFA052
MM/DD/YY
  XXXXXX                     INQUIRY MENU                 C20112WS HH:MM:SS


       BENEFICIARY/CWF          10    ZIP CODE FILE            19

       DRG (PRICER/GROUPER)     11    OSC REPOSITORY INQUIRY   1A

       CLAIM SUMMARY            12    CLAIM COUNT SUMMARY      56

       REVENUE CODES            13    HOME HEALTH PYMT TOTALS  67

       HCPC CODES               14    ANSI REASON CODES        68

       DX/PROC CODES ICD-9      15    CHECK HISTORY            FI

       ADJUSTMENT REASON CODES  16    DX/PROC CODES ICD-10     1B

       REASON CODES             17

   ENTER MENU SELECTION: 12


     PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```


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2. The Claim Summary Inquiry screen (Map 1741) appears:

```
  MAP1741                  CGS J15 MAC - Part A REGION        ACPFA052
MM/DD/YY
  XXXXXX    SC             CLAIM SUMMARY INQUIRY            C20112WS HH:MM:SS
                              NPI
        HIC                PROVIDER                S/LOC     TOB
   OPERATOR ID XXXXXX     FROM DATE       TO DATE        DDE SORT
   MEDICAL REVIEW SELECT
     HIC             PROV/MRN  S/LOC     TOB    ADM DT FRM DT THRU DT REC DT
SEL  LAST NAME  FIRST INIT TOT CHG  PROV REIMB PD DT  CAN DT REAS NPC #DAYS




      PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
  PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD
```

You can use the following function keys to move within the Claim Summary Inquiry screen and within the different claim pages:

- F3 – Exit (return to the Inquiry Menu)
- F5 – Scroll back through a list of claims or revenue code pages
- F6 – Scroll forward through a list of claims or revenue code pages
- F7 – Move one claim page back
- F8 – Move one claim page forward
- F10 – Move to the left page
- F11 – Move to the right page

Shift+Tab– Move from the right to left in valid fields (ex. Move from the HIC field to the NPI field)

Checking the Status of Your Claims/Beneficiary Claim History

When the Claim Summary Inquiry screen displays, your cursor will be located in the HIC field. However, to check the status of claims, you must first enter your facility's NPI. Therefore, to move the cursor to the NPI field, hold down the Shift key and press the Tab key. You cursor will automatically move to the NPI field.

There are two primary ways that you can view the status of your claims using option 12: by beneficiary's HICN, or by status/location within FISS.

1. **To view information using a beneficiary HICN,** follow these instructions:
   a. Type your facility's NPI number in the **NPI** field.
   b. Type the beneficiary's HICN in the **HIC** field. Press ***Enter***.

```
  MAP1741                  CGS J15 MAC - Part A REGION          ACPFA052 MM/DD/YY
  XXXXXX    SC             CLAIM SUMMARY INQUIRY              C20112WS HH:MM:SS
                              NPI 1234567890
        HIC 123456789A     PROVIDER                S/LOC         TOB
  OPERATOR ID XXXXXX      FROM DATE       TO DATE            DDE SORT
  MEDICAL REVIEW SELECT
    HIC             PROV/MRN   S/LOC     TOB    ADM DT FRM DT THRU DT  REC DT
SEL LAST NAME    FIRST INIT  TOT CHG  PROV REIMB PD DT  CAN DT REAS NPC #DAYS




      PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
  PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD
```


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Only the billing transactions that your facility submitted under the beneficiary's HICN and NPI will display. You will not have access to claims submitted by other providers.

c. After you press ***Enter***, FISS will search and display all claims submitted by your facility for that specific beneficiary. A maximum of 5 claims will display. If 5 claims display, press your F6 key to scroll forward to see if there are additional claims.

```
  MAP1741                        CGS J15 MAC - Part A REGION          ACPFA052 MM/
DD/YY
  XXXXXX     SC            CLAIM SUMMARY INQUIRY                     C20112WS
HH:MM:SS
                                  NPI 1234567890
        HIC 123456789A     PROVIDER                 S/LOC          TOB
   OPERATOR ID XXXXXX      FROM DATE          TO DATE           DDE SORT
   MEDICAL REVIEW SELECT
     HIC             PROV/MRN    S/LOC       TOB    ADM DT FRM DT THRU DT   REC DT
SEL  LAST NAME    FIRST INIT   TOT CHG    PROV REIMB PD DT   CAN DT REAS NPC #DAYS
  123456789A    XXXXXX             P B9997    131    0817XX 0817XX 0817XX    0902XX
   SMITH                 J                 684.00    0908XX 1030XX  37185

  123456789A    XXXXXX             P B9997    131    0817XX 0817XX 1015XX    1019XX
   SMITH                 J       1089.00  1140.00    1030XX         37185




      PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
  PRESS PF3-EXIT   PF5-SCROLL BKWD   PF6-SCROLL FWD
```

If no claims appear after you press Enter, check the HICN to ensure it is entered correctly. You may need to verify whether the HICN was changed by accessing the beneficiary's eligibility information.

When the information appears, you will see a two-line summary of each claim's information. To see more detail, you can select a specific claim, which will provide six pages of complete claim information. Additional pages will display when a claim has been selected for Medical Review and requires additional information be submitted via the ADR process.

d. To select a claim, press your Tab key until your cursor moves under the **SEL** field and is to the left of the HICN of the claim detail you want to view. Type ***S*** in the **SEL** field and press ***Enter***. You can only select one claim at a time.

```
  MAP1741                      CGS J15 MAC - Part A REGION              ACPFA052
MM/DD/YY
  XXXXXX     SC              CLAIM SUMMARY INQUIRY                     C20112WS
HH:MM:SS
                                  NPI 1234567890
        HIC 123456789A     PROVIDER                 S/LOC          TOB
   OPERATOR ID XXXXXX      FROM DATE          TO DATE           DDE SORT
   MEDICAL REVIEW SELECT
     HIC             PROV/MRN    S/LOC       TOB    ADM DT FRM DT THRU DT   REC DT
SEL  LAST NAME    FIRST INIT   TOT CHG    PROV REIMB PD DT   CAN DT REAS NPC #DAYS
S 123456789A    XXXXXX             P B9997    131    0817XX 0817XX 0817XX    0902XX
   SMITH                 J                 684.00    0908XX 1030XX  37185



      PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
  PRESS PF3-EXIT   PF5-SCROLL BKWD   PF6-SCROLL FWD
```

Note in the above example that the cursor is one space away from (or to the left of) the HICN of the claim detail you want to select. If the cursor is immediately next to the HICN (_123… instead of _ 123), the cursor is not in the correct position.

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e. Page 01 of the "Inst Claim Inquiry" screen appears. You may view all pages of the claim by pressing the F7 and F8 function keys to page back and page forward through the claim. Refer to the following page for an example of page 01 of the claim.

Claim Example

```
MAP1711    PAGE 01              CGS J15 MAC - Part A REGION            ACPFA052
MM/DD/YY
XXXXXX     SC                   INST CLAIM INQUIRY                  C20112WS HH:MM:SS
  HIC 123456789A     TOB XXX   S/LOC P B9997 OSCAR XXXXXX       SV:   UB-FORM
NPI XXXXXXXXXX TRANS HOSP PROV                  PROCESS NEW HIC
PAT.CNTL#:                          TAX#/SUB:                 TAXO.CD:
  STMT DATES FROM 0817XX   TO 1015XX   DAYS COV      N-C        CO       LTR
  LAST SMITH                        FIRST JAMES           MI E   DOB 01011931
  ADDR 1 101 MAIN ST                        2 ANYTOWN, IA
  3                                    4                                  CARR:
  5                                    6                                   LOC:
ZIP 520012233  SEX M MS    ADMIT DATE 0817XX HR 01 TYPE 9 SRC 1 D HM       STAT 30
  COND CODES  01     02     03     04     05     06     07     08     09     10
OCC CDS/DATE  01              02             03             04             05
              06              07             08             09             10
  SPAN CODES/DATES  01                      02                    03
04                  05                      06                    07
08                  09                      10                    FAC.ZIP 52111
  DCN
       V A L U E  C O D E S  -  A M O U N T S  -  A N S I   MSP APP IND
01 61     99916.00          02                          03
04                          05                          06
07                          08                          09
37186                                                          <== REASON CODES
      PRESS PF3-EXIT   PF5-SCROLL BKWD   PF6-SCROLL FWD   PF8-NEXT   PF9-UPDT
```

f. After reviewing the claim, press F3 to return to the claim list (Map 1741). You can select a different claim, start a new search, or press F3 to return to the Inquiry Menu.

When you view claims within option 12, it is an "inquiry-only" option. You cannot enter, correct, adjust or cancel claims within option 12. You can only view the claim information. To enter, correct, adjust, and cancel claims, you must use other options in FISS.

2. **To view claims by a status code or by a status and location,** follow these steps.

a. On Map 1741, type your facility's NPI number in the **NPI** field. To move the cursor from the HIC field to the NPI field, hold down the Shift key and press the Tab key.

b. Tab to the **S/LOC** field and type the status code or the status/location that you wish to view and press ***Enter***. You may, for example, want to view claims that are on the payment floor (P B9996). Note that FISS automatically inserts one space between the status and the location codes.

When you view claims by status/location code, you will most likely be inquiring about claims in the following status/locations:

Status/Location	Description
P B9996	Payment floor
P B9997	Processed or paid claim
D B9997	Denied claim
R B9997	Rejected claim
T B9997	Claim needing correction
S B6001	Claim selected for an additional development request (ADR)

Any status/location code that appears on a claim can be entered into the S/LOC field. Entering the status/location in the S/LOC field enables you to see all the claims in that particular area of FISS.

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```
MAP1741                      CGS J15 MAC - Part A REGION              ACPFA052
MM/DD/YY
XXXXXX   SC                 CLAIM SUMMARY INQUIRY                   C20112WS
HH:MM:SS
                                NPI XXXXXXXXXX
       HIC                PROVIDER                S/LOC P B9996 TOB
  OPERATOR ID XXXXX      FROM DATE          TO DATE            DDE SORT
  MEDICAL REVIEW SELECT
       HIC             PROV/MRN    S/LOC       TOB    ADM DT FRM DT THRU DT  REC DT
 SEL  LAST NAME    FIRST INIT  TOT CHG    PROV REIMB PD DT  CAN DT REAS NPC #DAYS
```

For information about FISS status and location codes, refer to "About Status/Location Codes" found in Chapter 1 of this guide.If there are claims in the status/location that you entered, they will appear on Map 1741 after you press ***Enter***. There may be multiple beneficiaries listed. This is normal since the common element you are inquiring about is the status code or status/location code. When you search by beneficiary HICN, you are inquiring about that particular beneficiary; therefore, multiple beneficiaries will not be listed; however, multiple claims may display.

```
 MAP1741                      CGS J15 MAC - Part A REGION              ACPFA052
MM/DD/YY
 XXXXXX   SC                 CLAIM SUMMARY INQUIRY                   C20112WS HH:MM:SS
                                NPI XXXXXXXXXX
       HIC                PROVIDER                S/LOC P B9996  TOB
  OPERATOR ID XXXXXX     FROM DATE          TO DATE            DDE SORT
  MEDICAL REVIEW SELECT
     HIC             PROV/MRN    S/LOC       TOB    ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME    FIRST INIT  TOT CHG    PROV REIMB PD DT  CAN DT REAS NPC #DAYS
  222111222B   XXXXXX            P B9996     131  0726XX 0726XX 0923XX   1001XX
   SMITH               A     1600.00    1304.00  1015XX         37186

  444333444A   XXXXXX            P B9996     131  0730XX 0730XX 0927XX   1001XX
   WHITE               J     1200.00    1216.00  1015XX         37186

  666777666A   XXXXXX            P B9996     131  0810XX 0810XX 1008XX   1009XX
   JONES               S     1800.00    1296.00  1023XX         37186




      PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
  PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD
```

c. You can view individual claims by typing S in the SEL field next to the HICN of the individual claim.

Map 1741 will display a maximum of 5 claims at any given time. To see if there are additional claims, press your F6 key to scroll forward.

Claim Status Inquiry Examples

When you are inquiring about specific information, whether it is specific beneficiary claims history information or specific status/location code information, you can tailor your search using one or more additional fields. In addition to entering your NPI, a HICN and S/LOC, you can enter data in the **TOB** (type of bill), **FROM DATE**, and **TO DATE** fields (circled and bolded below) to further narrow your search.

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```
 MAP1741                    CGS J15 MAC - Part A REGION            ACPFA052
MM/DD/YY
  XXXXXX   SC              CLAIM SUMMARY INQUIRY                 C20112WS HH:MM:SS
                                NPI
        HIC                PROVIDER              S/LOC           TOB
  OPERATOR ID            FROM DATE             TO DATE          DDE SORT
  MEDICAL REVIEW SELECT
     HIC            PROV/MRN  S/LOC      TOB   ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME   FIRST INIT  TOT CHG   PROV REIMB PD DT  CAN DT REAS NPC #DAYS
```

1. **Type of Bill (TOB)**

   You can narrow the search of a beneficiary's claims by entering a type of bill (TOB). For example, to review outpatient final claims submitted for a beneficiary, type your facility's NPI in the **NPI** field; the beneficiary's HICN in the **HIC** field; and the home health type of bill code 131 in the **TOB** field.

```
 MAP1741                    CGS J15 MAC - Part A REGION            ACPFA052
MM/DD/YY
  XXXXXX   SC              CLAIM SUMMARY INQUIRY                 C20112WS HH:MM:SS
                              NPI NNNNNNNNNN
      HIC NNNNNNNNNA   PROVIDER              S/LOC           TOB 131
  OPERATOR ID            FROM DATE             TO DATE          DDE SORT
  MEDICAL REVIEW SELECT
     HIC            PROV/MRN  S/LOC      TOB   ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME   FIRST INIT  TOT CHG   PROV REIMB PD DT  CAN DT REAS NPC #DAYS
```

To search for a beneficiary's claims for specific dates of service **and** specific type of bill, type your facility's NPI, the beneficiary's HICN, the type of bill, and the "from" and "to" dates. Entering a status code or status/location will further narrow your search. (See example below).

```
 MAP1741                    CGS J15 MAC - Part A REGION            ACPFA052
MM/DD/YY
  XXXXXX   SC              CLAIM SUMMARY INQUIRY                 C20112WS HH:MM:SS
                              NPI NNNNNNNNNN
      HIC NNNNNNNNNA   PROVIDER              S/LOC           TOB 131
  OPERATOR ID            FROM DATE 080113      TO DATE 093013   DDE SORT
  MEDICAL REVIEW SELECT
     HIC            PROV/MRN  S/LOC      TOB   ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME   FIRST INIT  TOT CHG   PROV REIMB PD DT  CAN DT REAS NPC #DAYS
```

It is a good idea to "refresh" your screen between different searches. Do this by pressing F3 to exit option 12. Then type ***12*** in the **Enter Menu Selection** field and press ***Enter***.

2. **From/To Date**

   If the beneficiary has an extensive claim history, you can narrow your search by adding from and to dates. These dates reflect the "from" and "to" dates of service billed on the claim. You may search by only using a "from" date, or both a "from" and "to" date. The "to" date can only be used if a "from" date is also entered. For example, to find claims with dates of service between August 1, 2013, to September 30, 2013, for a particular beneficiary, type your facility's NPI in the **NPI** field, the HICN in the **HIC** field, and type ***080113*** in the **FROM DATE** field and 093013 in the **TO DATE** field and press ***Enter***.

The top of the next page is an example of how this would appear before pressing ***Enter***.

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```
 MAP1741                    CGS J15 MAC - Part A REGION            ACPFA052
MM/DD/YY
  XXXXXX   SC              CLAIM SUMMARY INQUIRY                 C20112WS HH:MM:SS
                              NPI NNNNNNNNNN
       HIC NNNNNNNNNA   PROVIDER                 S/LOC          TOB
  OPERATOR ID           FROM DATE 080113      TO DATE 093013    DDE SORT
  MEDICAL REVIEW SELECT
     HIC            PROV/MRN  S/LOC      TOB   ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME   FIRST INIT  TOT CHG   PROV REIMB PD DT  CAN DT REAS NPC #DAYS
```

You may also use the **FROM DATE** field when searching for claims in a specific status/location. The example below shows how to access claims that were fully denied (D B9997) with dates of service on and after October 1, 2013, type the status/location D ***B9997*** in the **S/LOC** field, type ***100113*** in the **FROM DATE** field and leave the **TO DATE** field blank.

```
 MAP1741                    CGS J15 MAC - Part A REGION            ACPFA052
MM/DD/YY
  XXXXXX   SC              CLAIM SUMMARY INQUIRY                 C20112WS HH:MM:SS
                              NPI NNNNNNNNNN
       HIC NNNNNNNNNA   PROVIDER                 S/LOC D B9997   TOB
  OPERATOR ID           FROM DATE 080113      TO DATE           DDE SORT
  MEDICAL REVIEW SELECT
     HIC            PROV/MRN  S/LOC      TOB   ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME   FIRST INIT  TOT CHG   PROV REIMB PD DT  CAN DT REAS NPC #DAYS
```

Accessing Additional Development Request (ADR) Information

When claims are selected by Medical Review, CGS will request additional documentation from the provider to support the services being billed to Medicare. This request is called the Additional Development Request (ADR)

NOTE: The CMS Medicare Program Integrity Manual, Pub. 100-08, Ch. 3, Section 3.2.3.2 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf) requires providers to submit ADR documentation to CGS by day 30. If the documentation is not received timely, the claim will be denied.

The following pages explain how you can identify claims that CGS has requested additional documentation for, what documentation is being requested, and most importantly, the due date for when the ADR information must be received.

- Please refer to the "Key ADR Information" that follows these instructions. This information will help you avoid claim denials.

Identifying Claims Selected for ADR

You can easily see if claims are selected for ADR by accessing the Inquiry Menu and selecting option 12 (Claim Summary). Claims selected for ADR will appear in status/location S B6001.

CGS recommends that you check the ADR status/location (S B6001) at least once per week to help ensure timely responses.

1. On Map 1741, type your facility's NPI number in the **NPI** field. To move the cursor to the NPI field, hold down the Shift key and press the Tab key.
2. Tab to the **S/LOC** field and type S B6001. Press ***Enter***. If there are claims in the S B6001 status/location, they will appear after you press ***Enter***.

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```
 MAP1741                    CGS J15 MAC - Part A REGION            ACPFA052
MM/DD/YY
  XXXXXX   SC              CLAIM SUMMARY INQUIRY                 C20112WS HH:MM:SS
                                NPI NNNNNNNNNN
        HIC                PROVIDER              S/LOC D B6001    TOB
  OPERATOR ID              FROM DATE             TO DATE          DDE SORT
  MEDICAL REVIEW SELECT
     HIC              PROV/MRN  S/LOC      TOB   ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME    FIRST INIT  TOT CHG   PROV REIMB PD DT  CAN DT REAS NPC #DAYS
```

3. To identify the additional information being requested for each claim, you must select the claim by typing an S in the **SEL** field next to the HICN of the claim. Press ***Enter***. You can only select one claim at a time.

```
 MAP1741                    CGS J15 MAC - Part A REGION            ACPFA052
MM/DD/YY
 XXXXXX    SC              CLAIM SUMMARY INQUIRY                 C20112WS
HH:MM:SS
                               NPI XXXXXXXXXX
        HIC                PROVIDER              S/LOC S B6001    TOB
  OPERATOR ID XXXXXX       FROM DATE          TO DATE             DDE SORT
  MEDICAL REVIEW SELECT
     HIC              PROV/MRN     S/LOC      TOB   ADM DT FRM DT THRU DT  REC DT
SEL  LAST NAME    FIRST INIT  TOT  CHG    PROV REIMB  PD DT  CAN DT REAS NPC #DAYS
  NNNNNNNNA      XXXXXX            S B6001     XXX   1204XX  1204XX 0119XX   0212XX
   LASTNAME               M      1700.00                                39700

S NNNNNNNNA      XXXXXX            S B6001     XXX   1025XX  1025XX 1110XX   0212XX
   LASTNAME               J       300.00                                39700

  NNNNNNNNA      XXXXXX            S B6001     XXX   1115XX  1115XX 1215XX   0212XX
   LASTNAME               R       336.00                                39700

  NNNNNNNNA      XXXXXX            S B6001     XXX   1019XX  1019XX 1217XX   0212XX
   LASTNAME               T      1000.00                                39700



     PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
  PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD
```

4. Page 01 of the claim appears (Map 1711).

```
 MAP1711  PAGE 01          CGS J15 MAC - Part A REGION            CPFA052 MM/
DD/YY
XXXXXX    SC                INST CLAIM INQUIRY                  C20112WS HH:MM:SS
 HIC 444555666A    TOB XXX  S/LOC S B6001 OSCAR XXXXXX          SV:    UB-FORM
NPI NNNNNNNNNNN TRANS HOSP PROV                  PROCESS NEW HIC
PAT.CNTL#:                      TAX#/SUB:                 TAXO.CD:
 STMT DATES FROM 1025XX  TO 1110XX  DAYS COV      N-C       CO      LTR
 LAST SMITH                    FIRST JAMES          MI E  DOB 01011931
 ADDR 1 101 MAIN ST                    2 ANYTOWN, IA
 3                                4                              CARR:
```

5. ADR information is electronically attached to the end of the claim, as pages 07 and 08. To view the ADR information, type 07 in the **PAGE** field (if your cursor is not already in this field, press the HOME button found on your keyboard) and press ***Enter***.

The **"ORIG REQ DT"** field on **Page 07** indicates the date CGS requested the additional information. Documentation should be mailed no later than 30 days after this date. This allows for ample mail time, and processing of the documentation when received by CGS. Page 07 also identifies the address to which your documentation should be mailed.

The **"DUE DATE"** field is 45 days from the original request date (**ORIG REQ DT**). **To ensure documentation is received timely, providers are required to submit ADR documentation to CGS by day 30 (15 days before the DUE DATE)**. Documentation not received by the DUE DATE will result in the claim being denied.

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Example: FISS Page 07

```
REPORT: 001                MEDICARE PART A 15XXX        PVDR NO  : XXXXXXXXXX
 DATE  : MM/DD/CCYY   ADDITIONAL DEVELOPMENT REQUEST    BILL TYPE: 813
 CASE ID: 15004XXXXXXXXXXXXXXPAR0PR
                    ANYNAME HEALTH CENTER
                    1111 MAIN ST

                    ANYTOWN            IA 52001 1111

 WE HAVE REVIEWED THIS CLAIM RECORDS AND FOUND THAT ADDITIONAL DEVELOPMENT
 WILL BE NECESSARY BEFORE PROCESSING CAN BE FINALIZED.  TO ASSIST YOU IN
 PROVIDING THE REQUIRED INFORMATION, WE HAVE ASSIGNED REASON CODES TO THE
 AFFECTED CLAIM RECORD (SEE BELOW)FOR YOUR REVIEW.  PLESAE REFER TO THE
 ACCOMPANYING LIST FOR EXPLANATION OF THE ASSIGNED CODES.  WE MUST RECEIVE
 THE REQUESTED INFORMATION BEFORE THE DUE DATE LISTED BELOW, OR THE CLAIM
                    CGS J15 MAC
                    J15 - Part A PCC
                    P O BOX 20200
                    NASHVILLE             TN 37202
 PATIENT CNTRL NBR: XXXXXXX-XXXXXXX       DUE DATE: 04/23/20XX
 MEDICAL REC NO:                    DCN: XXXXXXXXXXXXXXPAR
 HIC: NNNNNNNNNA     PATIENT NAME: FIRSTNAME LASTNAME
 FROM DATE: 02/01/20XX  THRU DATE: 02/29/20XX  OPR/MED ANALYST:
 TOTAL CHARGES:      1000.00     ORIG REQ DT: 03/09/20XX  CLM RCPT DT: 03/07/20XX
      PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF8-NEXT  PF9-UPDT
```

Press ***F6*** to view the entire message. Press ***F5*** to scroll backward.

```
REPORT: 001                MEDICARE PART A 15XXX        PVDR NO  : XXXXXXXXXX
 DATE  : MM/DD/CCYY   ADDITIONAL DEVELOPMENT REQUEST    BILL TYPE: 813
 CASE ID: 15004XXXXXXXXXXXXXXPAR0PR
                    ANYNAME HEALTH CENTER
                    1111 MAIN ST

                    ANYTOWN            IA 52001 1111

  WILL BE DENIED LACK OF RESPONSE. ONE WAY THE CONTRACTOR ACCEPTS SOLICITED
  DOCUMENTATION FROM PROVIDERS IS VIA ELECTRONIC SUBMISSION OF MEDICAL
  DOCUMENTATION (ESMD) MECHANISM. FOR MORE INFORMATION ABOUT ESMD, SEE
  WWW.CMS.GOV/ESMD. SOLICITED LETTERS CAN BE ANY ADR LETTERS AT THE
  CONTRACTORS' DISCRETION, AND NOT SOLEY FOR MEDICAL REVIEW. YOU MAY FAX YOUR
  RESPONSE TO: 515-471-7581. YOU MAY MAIL YOUR RESPONSE TO THE ATTENTION OF:
                     CGS J15 MAC
                     J15 - Part A PCC
                     P O BOX 20200
                     NASHVILLE             TN 37202
PATIENT CNTRL NBR: XXXXXXX-XXXXXXX        DUE DATE: 04/23/20XX
 MEDICAL REC NO:                    DCN: XXXXXXXXXXXXXXPAR
 HIC: NNNNNNNNNA     PATIENT NAME: FIRSTNAME LASTNAME
 FROM DATE: 02/01/20XX  THRU DATE: 02/29/20XX  OPR/MED ANALYST:
 TOTAL CHARGES:      1000.00     ORIG REQ DT: 03/09/20XX  CLM RCPT DT: 03/07/20XX
      PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF8-NEXT  PF9-UPDT
```

6. To determine what documentation is being requested, press your F8 key to review the reason code narrative on FISS Page 08. The edit that the claim was selected for will appear in the upper left hand corner. Refer to the following page for an example of FISS Page 08.

You may need to press ***F6*** to see the remaining reason code narrative that identifies the documentation that you need to submit.

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Example: FISS Page 08

```
REASONS: 59BX9
REASON CODE NARRATIVES FOR HIC/DCN: NNNNNNNNNA XXXXXXXXXXXXXXXXR

59BX9 MEDICARE NEEDS TO RECEIVE THE RETURNED ADR INFORMATION BY THE 30TH DAY.
      THIS ALLOWS FOR MAIL TIME AND FOR US TO MOVE THE CLAIM INTO THE MEDICAL
      REVIEW STATUS/LOCATION SM50MR BY DAY 45 OR IT WILL BE DENIED WITH REASON
      CODE 56900 ON THE 46TH DAY. SEND THE FOLLOWING CHECK-LIST OF INFORMATION
      TO SUPPORT THE TERMINAL ILLNESS AND SERVICES BILLED:
      *INITIAL ASSESSMENT,ALL VISIT NOTES
      *PLAN OF CARE/CHANGES AND INTERDISCIPLINARY GROUP NOTES,
      *PHYSICIAN ORDERS AND VISIT NOTES
      *HOSPITAL DISCHARGE AND/OR PHYSICIAN SUMMARIES
      *HISTORY AND PHYSICAL EXAM, LAB, X-RAY, AND/OR SURGICAL REPORTS
      *SIGNED/DATED: CERTIFICATION, TRANSFER, REVOCATIONS
      *ANY PERTINENT INFORMATION PRIOR TO/AFTER THIS BILLING PERIOD
      *DATES AND TIMES OF SERVICE CHANGES, WHEN BILLING MULTIPLE LEVELS OF CARE
      *THE BENEFICIARY SIGNED AND DATED HOSPICE ELECTION STATEMENT.
      * SIGNED AND DATED HHABN OR NOTICE OF NON-COVERAGE IF ONE WAS ISSUED TO THE
      BENEFICIARY
      THIS EDIT SELECTS CLAIMS DUE TO PREVIOUS DENIALS FOR THIS BENEFICIARY.
      MEDICARE REQUIRES THAT MEDICAL RECORD ENTRIES FOR SERVICES PROVIDED/ORDER
      BE AUTHENTICATED BY THE AUTHOR.  THE METHOD USED SHALL BE A HANDWRITTEN ON
      AN ELECTRONIC SIGNATURE.  PATIENT IDENTIFICATION, DATE OF SERVICE, AND
```

Press ***F6*** to see the remaining reason code narrative that identifies the documentation that you need to submit.

```
REASONS: 59BX9

REASON CODE NARRATIVES FOR HIC/DCN: NNNNNNNNNA XXXXXXXXXXXXXXPAR

     PROVIDER OF THE SERVICE/ORDER MUST BE CLEARLY AND LEGIBLY IDENTIFIED ON
     THE SUBMITTED DOCUMENTATION.
     THE DOCUMENTATION YOU SUBMIT IN RESPONSE TO THIS REQUEST SHOULD COMPLY
     WITH THESE REQUIREMENTS.  IF YOU QUESTION THE LEGIBILITY OF ANY SIGNATURE
     YOU MAY SUBMIT AN ATTESTATION STATEMENT OR SIGNATURE LOG WITH YOUR ADR
     RESPONSE. FOR MORE INFORMATION SEE THE MLN MATTERS ARTICLE MM6698 WHICH CAN
     BE FOUND AT WWW.CMS.HHS.GOV/MLNMATTERSARTICLES.
     OMB CONTROL #: XXXX-XXXX
```

To go back to FISS Page 07, press your F7 key.

7. **Make a copy of Page 07 and attach it to the top page of your medical record documentation.** This ensures that the documentation will be matched with the correct claim. Mail it to the address listed on Page 07 as soon as possible.

You may also want to keep a printed a copy of pages 07 and 08 (reason code narrative) as a reference of what was requested and to document when you submitted the information. Pages 07 and 08 will no longer display after the documentation is received and the claim is moved from status/location S B6001 to S M50MR. For information on how to screen print FISS claim pages, refer to the FISS Overview chapter of this guide.

8. Press ***F3*** to exit back to Map 1741 or press ***F7*** to move back through the claim pages. If you have additional claims in the ADR status/location, you must select each claim individually to determine what documentation needs to be submitted to CGS and by what date.

You may want to "refresh" your screen to ensure accurate information displays. Press ***F3*** to exit option 12. Then type ***12*** in the **Enter Menu Selection** field and press ***Enter***. Retype your NPI and the status/location ***S B6001*** in the **S/LOC** field.

You are responsible for checking your claims to see if they are in the ADR status/location, as this is the only notification you will receive regarding your claims that have been selected for Medical

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Review by CGS. In addition, you should keep track of the claims for which you have submitted ADR documentation.

Key ADR Information

- **CMS requires providers to submit ADR documentation to CGS by day 30.** However, CGS must receive and process the additional information by the 45th day after the date of request (Orig Req Dt) shown on FISS Page 07.
- Make a copy of Page 07 and attach it to the top page of your medical record documentation. Mail the documentation to the address that appears on FISS Page 07.
- Once received by CGS, the documentation is scanned into the Optical Character Recognition (OCR) software, and CGS staff will move the claim from status/location S B6001 into status/location S M50MR pending review of the documentation.
- If CGS does not receive the requesteds information by day 45, the claim will automatically deny on day 46 and move to status/location D B9997 with reason code 56900 and your only recourse for Medicare payment is to request a Reopening. Refer to the Reopenings Web page for additional information (http://www.cgsmedicare.com/parta/appeals/reopenings.html).

NOTE: If the documentation was received timely (by day 45), but the claim automatically denied on day 46, CGS will proceed with reviewing the documentation, and there is no need to request a Reopening.

- CGS's review of your documentation can take up to 60 days from when the documentation was received. Once the review is completed, the claim is moved to status/location S M5CLM for additional processing.
- **Missing or Illegible Signature Documentation:** If, during review of your documentation, it is determined that a signature is missing or illegible, the claim will be re-ADRd to status/location S B6001. Page 08 will show the **Reasons** field with 5ADR2, and the narrative will indicate that additional documentation is required to support the signatures. The **Remarks** field on FISS Page 04 will specify the documentation being requested. **The additional signature documentation must be sent to CGS within 15 days of the request.**
- You may choose to submit documentation electronically. See the esMD (http://www.cgsmedicare.com/parta/pubs/news/2012/0312/288.html) article for more information about electronic submission of documentation.

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```
MAP171A     PAGE 02         CGS J15 MAC - Part A REGION          ACPFA052
XX/XX/XX
XXXXXX      SC              INST CLAIM INQUIRY                   C201135E XX:XX:XX
DCN XXXXXXXXXXXXXXXX          HIC NNNNNNNNNA       RECEIPT DATE 1104XX   TOB 131
STATUS  P LOCATION B9997      TRAN DT XXXXXX       STMT COV DT 0103XX    TO 0302XX
  4                    SERV      SERV
 REV   HCPC MODIFIERS  DATE      RATE    TOT-UNT   COV-UNT   TOT-CHRG    COV-CHRG
0324   71010          0103XX                60        60
  ANES  CF       ANES BV                              PC/TC IND
  HCPC TYPE       DEDUCTIBLES       COINSURANCE         ESRD-RED/     VALCD-05/
                BLOOD       CASH   WAGE-ADJ     REDUCED     PSYCH/HBCF         OTHER
  PAT ->
  MSP ->                                    ANSI ->                    PAY/HCPC
  MSP ->                                 OUTLIER ->                    APC CD 00260
           PAYER-1     PAYER-2         OTAF  DENIAL        OCE FLAGS
  MSP ->                                      IND 1  2  3  4  5  6  7  8  9
  ID ->                                           X
        REIMB       RESP          PAID          REDUCT-AMT                  ANSI
  PAT ->                                                    LABOR       NON-LABOR
 PROV ->      4369.91
  MED ->      4369.91                    PRICER        PAY                      ASC
            ADJUSTMENT   ANSI       AMT    RTC    METHOD   IDE/NDC/UPC       GRP %
CONTR-       4369.91-    CO 97    4369.91
37186                                                          <== REASON CODES
PRESS PF2-1712   PF3-EXIT   PF5-UP   PF6-DOWN   PF7-PREV   PF8-NEXT PF10-LEFT PF11-RIGHT
```

In the screen example above, the fields that appear in bold type are fields that you will want to review to identify Pricer downcoding/upcoding information.

REV – This field identifies the revenue code line that displays. The detail includes the revenue code, HCPC code, service date (SERV DATE), total units (TOT-UNT) and covered units (COV-UNT).

APC CD – This field displays the APC code.

OCE FLAGS – This field will display a "X" indicating that the line item "paid under OPPS; Separate APC payment"

- To view Pricer information for another line item revenue code, use your ***F5*** and ***F6*** keys to scroll up or down until you see the appropriate line item displayed in the REV field.
- Press ***F2*** (or F10 twice) to return to Map 1712. Press ***F3*** to return to the Claim Summary Inquiry screen (Map 1741).

Map 171A field descriptions can be found later in this chapter, directly following the field descriptions for Map 1741.

Field Descriptions for Option 12 – Claims

Map 1741 Screen Example

```
MAP1741                   CGS J15 MAC Part A REGION              ACPFA052 XX/
XX/XX
XXXXXX      SC            CLAIM SUMMARY INQUIRY                  C201135E
XX:XX:XX
                           NPI
      HIC                PROVIDER                 S/LOC               TOB
 OPERATOR ID             FROM DATE            TO DATE                 DDE SORT
 MEDICAL REVIEW SELECT
      HIC          PROV/MRN  S/LOC       TOB    ADM DT   FRM DT  THRU DT   REC DT
SEL  LAST NAME  FIRST INIT  TOT CHG   PROV REIMB PD DT    CAN DT   REAS NPC #DAYS




        PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
PRESS PF3-EXIT     PF5-SCROLL BKWD     PF6-SCROLL FWD
```


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Map 1741 Field Descriptions	
NPI	National provider identifier.
HIC	The beneficiary's Health Insurance Claim Number (HICN).
PROVIDER	Not applicable.
S/LOC	Status and location code assigned to the claim by FISS.
TOB	The type of bill submitted on the CMS-1450 claim form. The first two positions are required for a search. The third position is optional.
OPERATOR ID	Identifies the operator ID utilizing the screen.
FROM DATE	"From" date of service (MMDDYY format).
TO DATE	"Through" date of service (MMDDYY format).
DDE SORT	This field is not functional through the Inquiry Menu. Refer to the Claims Corrections chapter of this guide for more information.
MEDICAL REVIEW SELECT	Not in use.
First Line of Data	
HIC	The beneficiary's Health Insurance Claim Number (HICN).
PROV/MRN	Medicare provider number assigned to your facility.
S/LOC	Status/location. This code is assigned to the claim by FISS. Refer to Chapter 1 of this guide for additional information.
TOB	Type of bill. The type of bill code submitted on the CMS-1450 claim form.
ADM DT	Admission date. The date the beneficiary was admitted for care.
FRM DT	"From" date of service (MMDDYY format).
THRU DT	"Through" date of service (MMDDYY format).
REC DT	Received date. The date CGS originally received the claim or the date the claim was corrected from the Return to Provider (RTP) file.
Second Line of Data	
SEL	Selection. This field is used to select the claim you wish to view.
LAST NAME	Last name of the beneficiary.
FIRST INIT	First initial of the beneficiary's name.
TOT CHG	Total charge. The total charge submitted on the CMS-1450 claim form.
PROV REIMB	Provider reimbursement. The amount reimbursed to the provider for an individual claim.
PD DT	Paid date. The date the claim will pay (for claims in P B9996) or was paid (P B9997). For claims in RTP (T B9997), this is the date the claim went to the RTP status/location. For claims rejected (R B9997) or denied (D B9997), this is the date the claim rejected or denied.
Second Line of Data (continued)	
CAN DT	Cancel date. The date the original claim was canceled.
REAS	Reason code. The code assigned by FISS describing what is happening to the claim (edit).
NPC	Non-payment code. The code indicating why payment was not made. Values are: **B** Benefits exhausted **N** All other reasons **P** Payment requested **R** Spell of illness benefits refused, certification refused, failure to submit evidence, provider responsible for not filing timely,ro Waiver of Liability **W** Workers compensation **X** MSP cost avoided **Z** System set for type of bills 322 and 332 – MSP Primary Payer NOTE: this code displays on home health Requests for Anticipated Payment (RAPs) when there is another insurer that is primary to Medicare. HHAs do not receive payment for RAPs when there is another insurance that may pay primary to Medicare.
# DAYS	Number of days. The number of days the claim has been in the Return to Provider (RTP) status. This field is only functional through the Claim and Attachments Corrections Menu. Refer to Chapter 5 of this guide for additional information.

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Field Descriptions for Map 171A

Map 171A Screen Example

```
MAP171A       PAGE 02            CGS J15 MAC - Part A REGION       ACPFA052
XX/XX/XX
XXXXXX        SC                  INST CLAIM INQUIRY              C201135E XX:XX:XX
DCN                                HIC               RECEIPT DATE          TOB
STATUS        LOCATION             TRAN DT           STMT COV DT           TO
                                SERV        SERV
 REV    HCPC  MODIFIERS         DATE        RATE    TOT-UNT  COV-UNT  TOT-CHRG COV-CHRG

 ANES CF               ANES BV                                PC/TC IND
HCPC TYPE              DEDUCTIBLES          COINSURANCE        ESRD-RED/  VALCD-05/
              BLOOD           CASH      WAGE-ADJ      REDUCED  PSYCH/HBCF    OTHER
PAT ->
MSP ->                                                 ANSI ->             PAY/HCPC
MSP ->                                               OUTLIER ->            APC CD
             PAYER-1       PAYER-2        OTAF     DENIAL       OCE FLAGS
MSP ->                                              IND  1  2  3  4  5  6  7  8  9
 ID ->
          REIMB        RESP          PAID          REDUCT-AMT                  ANSI
 PAT ->                                                      LABOR          NON-LABOR
PROV ->
 MED ->                                 PRICER         PAY                      ASC
         ADJUSTMENT  ANSI            AMT     RTC     METHOD    IDE/NDC/UPC       GRP %
 CONTR-
                                                                  <== REASON CODES
PRESS PF2-1712 PF3-EXIT PF5-UP  PF6-DOWN  PF7-PREV  PF8-NEXT  PF10-LEFT  PF11-RIGHT
```

Map 171A Field Descriptions Fields prior to the start of the revenue code line item information (first four rows of information) are system generated from Page 01 of the claim.	
UNTITLED	Claim line item number (1 – 450).
REV	Revenue code – identifies the revenue code for specific billed service.
HCPC	Healthcare Common Procedure Code – identifies the HCPC code that further defines the revenue code.
MODIFIERS	Healthcare Common Procedure Code System Modifier.
SERV DATE	Date service was provided.
SERV RATE	Per unit rate for revenue code line item service.
TOT-UNT	Total units.
COV-UNT	Covered units.
TOT-CHRG	Total charges per revenue code.
COV CHRG	Covered charges per revenue code.
ANES CF	Anesthesia Conversion Factor.
ANES BV	Anesthesia Base Units Value.
PC/TC IND	Professional Component / Technical Component. Not applicable to home health and hospice providers.
HCPC TYPE	An 'M' indicator will display when the HCPCS associated with the revenue line originated from the Medicare physician fee schedule.
PAT BLOOD DEDUCTIBLES	Patient Blood Deductibles.
PAT CASH DEDUCTIBLES	Patient Cash Deductibles.
REDUCED COINSURANCE	Reduced Coinsurance.
ESRD-RED/ PSYCH/HBCF	ESRD Reduction Amount/Psychiatric Reduction Amount/Hemophilia Blood Clotting Factor Amount.
VALCD-05/ OTHER	Value Code 05/Other. Identifies whether value code 05 is present on the claim.
MSP BLOOD DEDUCTIBLES	Medicare Secondary Payer Blood Deductibles.
MSP CASH DEDUCTIBLES	Medicare Secondary Payer Cash Deductibles.
MSP COINSURANCE	Medicare Secondary Payer Coinsurance.

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Map 171A Field Descriptions Fields prior to the start of the revenue code line item information (first four rows of information) are system generated from Page 01 of the claim.	
ANSI ESRD-RED/ PSYCH/ HBCF	ANSI End Stage Renal Disease Reduction/Psychiatric Coinsurance/Hemophilia Blood Clotting Factor.
ANSI VALCD-05/OTHER	ANSI Value Code-05/Other. Identifies the 2-position ANSI group code and 3-position ANSI reason (adjustment) code. The ANSI data for the value codes are reported on the Remittance Advice for the Value Code 05/Other amount.
MSP PAYER-1	Medicare Secondary Payer Payer-1. Identifies the amount entered by the provider (if available) or apportioned by FISS as payment from the primary payer. FISS, based on the amount used in payment calculation and the value code for the primary payer, apportions this amount.
MSP PAYER-2	Medicare Secondary Payer Payer-2. Identifies the amount entered by the provider (if available) or apportioned by FISS as payment from the secondary payer. FISS, based on the amount used in payment calculation and the value code for the secondary payer, apportions this amount.
OTAF	Obligated to Accept Payment in Full. Identifies the line item apportioned amount entered by the provider (if applicable) or apportioned amount calculated by the MSPPAY module of the obligated to accept as payment in full, when value code 44 is present.
MSP DENIAL IND	Medicare Secondary Payer Denial Indicator. Identifies to the MSPPAY module that an insurer primary to Medicare has denied this line item. The valid values are: " " – not denied D – denied
OCE FLAGS	**Flag 1 – Service Indicator – valid values are:** B – Non-allowed item or service for OPPS M – Medical Review changes a HIPPS code P – Pricer upcode/downcode; The Pricer program in FISS changes the HIPPS code to "early" or "late" based on the beneficiary's adjacent episode history posted to the Common Working File (CWF) and/or the claim contains more or less therapy revenue codes than indicated by the HIPPS code submitted. **Flag 2 – Payment Indicator** **Flag 3 – Discounting Formula Number** **Flag 4 – Line Item Denial or Rejection Flag** **Flag 5 – Packing Flag** **Flag 6 – Payment Adjustment Flag** **Flag 7 – Payment Method Flag** **Flag 8 – Line Item Action Flag** **Flag 9 – Composite Adjustment**
PAY/HCPC APC CD	Payment Ambulatory Patient Classification Code or HCPC Ambulatory Patient Classification Code.
MSP PAYER – 1 ID	Medicare Secondary Payer Payer-1 ID - Displays 1-position alphanumeric code identifying the specific payer. If Medicare is primary, this field will be blank. The valid values are: **1** – Medicaid **2** – BlueCross **3** – Other **4** – None **A** – Working Aged **B** – ESRD beneficiary in a 30-month coordination period with an employer group health plan **C** – Conditional payment **D** – Auto no-fault **E** – Worker's Compensation **F** – Public Health Service or other Federal Agency **G** – Disabled **H** – Black Lung **L** – Liability
MSP PAYER – 2 ID	Medicare Secondary Payer Payer-2 ID - Displays 1-position alphanumeric code identifying the specific payer. If Medicare is secondary, this field will be blank. The valid values are: **1** – Medicaid **2** – BlueCross **3** – Other **4** – None **A** – Working Aged **B** – ESRD beneficiary in a 12-month coordination period with an employer group health plan **C** – Conditional payment **D** – Auto no-fault **E** – Worker's Compensation **F** – Public Health Service or other Federal Agency **G** – Disabled **H** – Black Lung **L** – Liability

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Map 171A Field Descriptions Fields prior to the start of the revenue code line item information (first four rows of information) are system generated from Page 01 of the claim.	
PAT REIMB	Patient Reimbursement. This field identifies the system generated calculated line amount to be paid to the patient on the basis of the amount entered by the provider on Page 03 of the claim, in the "Due From PAT" field.
PAT RESP	Patient Responsibility. Identifies the amount for which the individual receiving services is responsible. The amount is calculated as follows: If Payer 1 indicator is C or Z, the amount equals: cash deductible + coinsurance + blood deductible. If Payer 1 indicator is not C or Z, the amount equals: MSP blood + MSP cash deductible + MSP coinsurance.
PAT PAID	Patient paid. Identifies the line item patient paid amount calculated by the system. This amount is the lower of (patient reimbursement + patient responsibility) or the remaining patient paid (after the preceding lines have reduced the amount entered on Page 03 of the claim).
REDUCT-AMT	Reduction amount. A 10 percent reduction in conjunction with Group Code "CO." Not applicable to home health and hospice providers.
ANSI	ANSI Group Code and the Claim Adjustment Reason Codes related to the reduction amount. Not applicable to home health and hospice providers.
PROV REIMB	Provider Reimbursement. Identifies the system generated calculated line amount to be paid to the provider.
LABOR	Identifies the labor amount of the payment as calculated by Pricer.
NON-LABOR	Identifies the non-labor amount of the payment as calculated by Pricer.
MED REIMB	Medicare Reimbursement. Identifies the total Medicare reimbursement for the line item, which is the sum of the patient reimbursement and the provider reimbursement.
CONTR ADJUSTMENT	Contractor Adjustment. Identifies the total contractual adjustment. The calculation is: submitted charge – deductible – wage adjusted coinsurance – blood deductible – value code 71 – psychiatric reduction – value code 05/other – reimbursement amount. Note: For MSP claims, the MSP deductible, MSP blood deductible, and MSP coinsurance is used in the above calculation in place of the deductible, blood deductible, and coinsurance amounts.
ANSI	ANSI Group – ANSI Adjustment Code - Identifies the 2-position ANSI group code and 3-position ANSI reason (adjustment) code. The ANSI data for the value codes are reported on the Remittance Advice.
PRICER AMT	Pricer Amount. Identifies the total reimbursement received from Pricer.
PRICER RTC	Pricer Return Code. Identifies the return code from the OPPS Pricer. This is a 2-digit field. The valid values are: ***Home Health Prospective Payment System (HH PPS)*** **Describes how the bill was paid** 00 Final payment where no outlier applies 01 Final payment where outlier applies 02 Final payment where outlier applies, but is not payable due to limitation (effective for claims when "TO" date is on/after January 1, 2010) 03 Initial percentage payment 0% 04 Initial percentage payment 50% 05 Initial percentage payment 60% 06 LUPA payment only 07 Final Payment, SCIC 08 Final Payment, SCIC with Outlier 09 Final Payment, PEP 11 Final Payment, PEP with Outlier 12 Final Payment, SCIC within PEP 13 Final Payment, SCIC within PEP with Outlier **Describes why the bill was not paid** 10 Invalid TOB 14 LUPA payment only 15 Invalid PEP days, for shortened episode 16 Invalid HRG days, greater than 60 20 PEP indicator invalid 25 Medical review indicator invalid 30 Invalid CBSA code 35 Invalid initial payment indicator 40 Invalid service thru date for current calendar year 70 Invalid or no HRG code present 75 No HRG present in 1st occurrence 80 Invalid revenue code 85 No revenue code present

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Map 171A Field Descriptions Fields prior to the start of the revenue code line item information (first four rows of information) are system generated from Page 01 of the claim.	
PAY METHOD	Payment Method. Identifies the payment method returned from OCE. **Valid values are:** 1 – paid standard OPPS amount (status indicators S, T, V, X, or P) 2 – services not paid under OPPS (status indicator A) 3 – not paid (status indicators W, Y, or E) or not paid under OPPS (status indicators B, C or Z) 4 – acquisition cost paid (status indicator F) 5 – additional payment for drug or biological (status indicator G) 6 – additional payment for device (status indicator H) 7 – additional payment for new drug or new biological (status indicator J) 9 – no additional payment included in line items with APCS (status indicator N, or no HCPCS code and certain revenue codes, or HCPCS codes Q0082 (activity therapy), G0129 (occupational therapy), or G0177 (partial hospitalization program services)
IDE/NDC/UPC	Identifies IDE, NDC, and UPC.
ASC GRP	Identifies the ASC group code for the indicated revenue code.
%	ACS Percentage. Identifies the percentage used by the ASC Pricer in its calculation for the indicated revenue code.

Field Descriptions for Map 171D

Map 171D Screen Example

```
MAP171D     PAGE 02            CGS J15 MAC - Part A REGION            ACPFA052
XX/XX/XX
XXXXXX       SC                 INST CLAIM INQUIRY                  C201135E
XX:XX:XX
DCN                               HIC                 RECEIPT DATE           TOB
STATUS     LOCATION               TRAN DT             STMT COV DT            TO
PROVIDER ID                       BENE NAME
NONPAY CD       GENER HARDCPY          MR INCLD IN COMP              CL MR IND
TPE-TO-TPE      USER ACT CODE          WAIV IND     MR REV URC       DEMAND
REJ CD          MR HOSP RED            RCN IND      MR HOSP-RO       ORIG UAC
MED REV RSNS
OCE MED REV RSNS
        HCPC/MOD IN      SERV                                    -----REASON-
CODES------
 REV  HCPC MODIFIERS     DATE    COV-UNT    COV-CHRG      ADR
                                                          FMR
ORIG                      ORIG REV            MR          ODC
OCE OVR    CWF OVR    NCD OVR   NCD DOC     NCD RESP       NCD#          OLUAC
        NON          NON    DENIAL OVER ST/LC    MED      ------------ANSI--------
----
LUAC  COV-UNT     COV-CHRG  REAS  CODE OVER     TEC      ADJ  GRP
------REMARKS------


TOTAL                             LINE ITEM REASON CODES
                                                          <== REASON CODES
 PRESS PF2-1712    PF3-EXIT    PF5-UP    PF6 DOWN   PF7-PREV   PF8-NEXT  PF10-LEFT
```

Map 171D Field Descriptions	
SC	Screen Control. A feature that allows you to access other FISS inquiry options.
DCN	Document Control Number. Displays the claim's identification number assigned by FISS when the claim is received.
HIC	Health Insurance Claim Number (HICN). Identifies the HICN assigned
RECEIPT DATE	Identifies the actual receipt date. This is automatically entered by FISS.
TOB	Type of Bill. Identifies the type of bill that applies to the claim.

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Map 171D Field Descriptions	
STATUS	Identifies the claim's status in the system (P, D, R, S, or T).
LOCATION	Further identifies the claim's location in the system.
TRAN DT	Transaction Date. Identifies the date of the latest update activity.
STMT COV DT	Statement Covers Date. Identifies the beginning date of service.
TO	Statement Covers "To" Date. Identifies the ending date of service.
PROVIDER ID	Provider Number. Identifies your facility's National Provider Identifier (NPI).
BENE NAME	Beneficiary Name. Identifies the name of the beneficiary.
NONPAY CD	Non-Pay Code. Identifies the reason for Medicare's decision not to make payment. Valid values are: **B** Benefits exhausted **N** All other reasons **P** Payment Requested **R** Spell of illness benefits refused, certification refused, failure to submit evidence, provider responsible for not filing timely,ro Waiver of Liability **W** Workers Compensation **X** MSP cost avoided MSP Primary Payer
GENER HARDCPY	Generate hardcopy. Instructs system to generate a specific type of hard copy document. Valid values are: **2** Medical ADR **3** Non-medical ADR **4** MSP ADR **5** MSP cost avoidance ADR **7** ADR to beneficiary **8** MSN (line item) or partial denial **9** MSN (claim level) or full denial
MR INCLD IN COMP	Composite Medical Review Included in Composite Rate.
CL MR IND	Complex Manual Medical Review Indicator. Identifies if all services on the claim received complex manual medical review. Valid values: **" "** The services did not receive manual medical review. **Y** Medical records received and this service received complex manual medical review. A "Y" will display when the OCE FLAGS field on Map 171A displays an "M" (Medical Review changes a HIPPS code). **N** Medical records were not received and this service received routine manual medical review.
TPE-TO-TPE	Tape to Tape flag. Displays the tape-to-tape flag indicating the system to either perform or skip a function. If the value in this field is "X", the claim data information is not posted to the Common Working File (CWF). If this field is blank, the claim data from the finalized (status/location P B9997, R B9997, or D B9997) billing transaction did post to CWF. Whenever claim data has posted to CWF, a cancel or adjustment must be submitted to remove or change this information. Valid values and the functions include:
USER ACT CODE	User Action Code. For intermediary use for medical review and reconsideration only. Valid values are: **A** – pay per waiver – full technical **B** – pay per waiver – full medical **C** – provider liability – full medical – subject to waiver provision **D** – beneficiary liability – full – subject to waiver provision **E** – pay claim – line full **F** – pay claim partial – claim must be updated to reflect liability **G** – provider liability – full technical – subject to waiver provision **H** – full/partial denial with multiple liabilities – claim must be updated to reflect liability **I** – full provider liability – medical – not subject to waiver provision **J** – full provider liability – technical – not subject to waiver provision **K** – full beneficiary liability – not subject to waiver provision **L** – full provider liability - code changed to reflect actual service **M** – pay per waiver – line or partial line **N** – provider liability – line or partial line

Function	Blank	A	J	O	Q	S	T	U	W	X	Z
Transmit To CWF	Y	Y	N	N	N	Y	Y	Y	Y	N	N
Print On Remittance	Y	Y	Y	N	Y	Y	N	N	N	Y	N

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Map 171D Field Descriptions	
USER ACT CODE (continued)	**O** – beneficiary liability – line or partial line **P** – open biopsy changed to closed biopsy **Q** – release with no medical review performed **R** – CWF denied but medical review was performed **Z** – force claim to be re-edited by medical policy **5** – set systematically from the reason code file to identify claims for which special processing is required **7** – force claim to be re-edited by medical policy edits in the 5XXXX range **8** – claim was suspended via an OCE MED review reason **9** – claim has been identified as a first claim review
WAIV IND	Waiver Indicator. Identifies whether the provider has their presumptive waiver status. This field is no longer used.
MR REV URC	Medical Review Utilization Review Committee Reversal.
DEMAND	Medical Review Demand Reversal –
REJ CD	Reject Code. Identifies the reason code for which the claim is being denied (on full claim denials only).
MR HOSP RED	Medical Review Hospice Reduced. For hospice claims, this field identifies the line item(s) has been reduced to a lesser charge by medical review. Valid values are: **Y** – Reduced **" "** – Not reduced
ORIG UAC	Original User Action Code. For intermediary use only.
MED REV RSNS	Medical Review Reasons. Identifies a specific error condition relative to medical review. There are up to nine medical review reasons that can be captured per claim. This field only displays medical review reasons specific to claim level.
OCE MED REV RSNS	OCE Medical Review Reasons.
Unlabeled	Identifies the line number of the revenue code. The line number is located above the revenue code field on this Map. To move to another revenue code, press F6 to scroll down and F5 to scroll up.
REV	Revenue Code.
HCPC/MOD IN	HCPCS Code/Modifier. Valid values are: **U** – upcoding **D** – downcoding **" "** – no downcoding
HCPC	Healthcare Common Procedure Coding System. Indicates 5-position HCPCS associated with the revenue code.
MODIFIERS	Healthcare Common Procedure Coding System Modifier.
SERV DATE	Service date. Line item date of service associated with the revenue code.
COV-UNT	Covered units. Reflects the number of covered visits associated with the revenue code.
COV-CHRG	Covered charges. Represents the covered charges associated with the revenue code.
ADR REASON CODES	Additional Development Request. ADR reason codes used when additional information has been requested.
FMR REASON CODES	Focused Medical Review Suspense Codes. Identifies the medical review suspense codes when a claim is edited based on the medical policy parameter file.
ODC REASON CODES	Original Denial Reason Code. Identifies the original denial reason codes.
ORIG	Original HCPCS or HIPPS code, or modifiers billed.
ORIG REV CODE	Original revenue code billed.
MR	Complex Manual Medical Review Indicator. Identifies if all services on the claim received complex manual medical review. Valid values are: **" "** – services did not receive manual medical review **Y** – medical records received and services received complex manual medical review **N** – medical records were not received and services received routine manual medical review

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Map 171D Field Descriptions	
OCE OVR	Override. Overrides the way the OCE module controls the line item. Valid values are: **0** – OCE line item denial or rejection is not ignored **1** – OCE line item denial or rejection is ignored **2** – External line item denial. Line item is denied even if no OCE edits. **3** – External line item reject. Line item is rejected even if no OCE edits. **4** – External line item adjustment. Technical charge rules apply.
CWF OVR	CWF Override. Overrides the way the OCE module controls the line item.
NCD OVR	National Coverage Determination Override Indicator. Identifies whether the line has been reviewed for medical necessity and should bypass the NCD edits, the line has no covered charges and should bypass the NCD edits, or the line should not bypass the NCD edits. Valid values are: " " – NCD edits are not bypassed **Y** – the line has been reviewed for medical necessity and bypasses the NCD edits **D** – the line has no covered charges and bypasses the NCD edits
NCD DOC	National Coverage Determination Documentation Indicator. Identifies whether the documentation was received for the necessary medical service. Valid values are: **Y** – the documentation supporting the medical necessity was received. **N** – the documentation supporting the medical necessity was not received.
NCD RESP	National Coverage Determination Response Code. Identifies the response code that is returned from the NCD edits. Valid values are: " " – default **0** – the HCPCS/diagnosis code matched the NCD edit table pass criteria. The line continues through the internal local medical necessity edits. **1** – the line continues through the internal local medical necessity edits because: the HCPCS code was not applicable to the NCD edit table process, the date of services was not within the range of the effective dates for the codes, the override indicator is set to Y or D, or the HCPCS code field is blank. **2** – none of the diagnoses supported the medical necessity of the claim, but the documentation indicator shows that the documentation to support medical necessity is provided. The line suspends for medical review. **3** – the HCPCS/diagnosis code matched the NCD edit table list ICD-9-CM deny codes. The line suspends and indicates that the service is not covered and is to be denied as beneficiary liable due to noncoverage by statute. **4** – none of the diagnosis codes on the claim support the medical necessity for the procedure and no additional documentation is provided. This line suspends as not medically necessary and will be denied. **5** – diagnosis codes were not passed to the NCD edit module for the NCD HCPCS code. The claim suspends and will move to the Return to Provider (RTP) file.
NCD #	National Coverage Determination Number. This field identifies the NCD number associated with the beneficiaries claim denial. This is an eight-position alphanumeric field.
OLUAC	Original Line User Action Code. Identifies the original line user action code and is only used when there is a line user action code and a corresponding medical review denial reason code in the Benefits Savings portion of the claim.
LUAC	Line User Action Code. This is a 2-position field. The 1st position indicates the cause of the denial reason for the specific revenue line (see the USER ACT CODE field of this FISS Guide chapter for valid values). The 2nd position indicates the reconsideration code. A value equal to R indicates that reconsideration has been performed.
NON COV-UNT	Noncovered units. Contains the number of units that are being denied, if applicable.
NON COV-CHRG	Noncovered charges. Identifies the total of denied/rejected/noncovered charges for each line item being denied.
DENIAL REAS	Denial Reason. Identifies the reason code associated with the denial for the revenue code line.
OVER CODE	Override Code. Overrides the system generated ANSI codes from the denial reason code file. The valid values are: **A** – override system generated ANSI code " " – system default

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Map 171D Field Descriptions	
ST/LC OVER	Status/location Override. Overrides the reason code file status. Only used by CGS. Valid values are: **D** – denied line item for the reason code. **R** – rejected the line item for the reason code **" "** – processed claim with no override action
MED TEC	Medical Technical Denial Indicator. Identifies the appropriate Medical Technical Denial indicator used when performing the medical review denial of a line item. The valid values are: **M** – medical denial and waiver was applied **S** – medical denial and waiver was not applied **T** – technical denial and waiver was applied **U** – technical denial and waiver was not applied
ANSI ADJ	ANSI Adjustment Reason Code. Identifies the ANSI adjustment reason code associated with the denial reason for each line item.
ANSI GRP	ANSI Group Code. Contains the ANSI group code associated with the denial reason for each line item.
ANSI REMARKS	ANSI Remarks Code. Contains the ANSI remarks codes associated with the denial reason for each line item.
TOTAL	Contains the sum of all revenue code noncovered units.
LINE ITEM REASON CODES	Identifies the reason code that is assigned for suspending the line item.

Archived Claims

FISS archives claim data on processed claims after 18 months from the date the claim is processed. Archived claims can be identified by status/location P O9998 or R O9998 (the letter "O" as in "offline" and not a "0" (zero)).

These claims can be accessed by selecting 12 (Claims) from the Inquiry Menu; typing your NPI in the NPI field, and entering the beneficiary's HICN in the HIC field. Then tab to the S/LOC field and, enter P O9998 or R O9998. Press Enter. Archived claims do not display the beneficiary's name or provider reimbursement (PROV REIMB) amount, and if selected (type an S in the SEL field) all claim pages appear blank. The message "ADJUSTMENT CLAIM IS PRESENTLY OFFLINE PF10 TO RETRIEVE" will display.

Although the claim data is archived, you are able to retrieve an archived claim to inquire into how it was submitted and processed. For additional information on how to retrieve an archived claim, refer to Chapter 5 of this guide.

Please note, that because Section 6404 of the Patient Protection and Affordable Care Act (PPACA) amended the timely filing requirements to one calendar year after the date of service, adjustments or claim cancellations cannot be done after a claim has been archived, unless a valid exception to timely filing has been met. See the "Medicare Timely Filing Guidelines" (http://www.cgsmedicare.com/Articles/COPE18411.html) Web page for more information.

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```
MAP1741                      CGS J15 MAC - Part A REGION                ACPFA052
XX/XX/XX
XXXXXX      SC              CLAIM SUMMARY INQUIRY                     C201135E
XX:XX:XX
                              NPI XXXXXXXXXX
      HIC NNNNNNNNND     PROVIDER                  S/LOC P O9998    TOB
OPERATOR ID              FROM DATE          TO DATE               DDE SORT
MEDICAL REVIEW SELECT
     HIC             PROV/MRN      S/LOC       TOB     ADM DT    FRM DT    THRU DT
REC DT
SEL LAST NAME    FIRST INIT  TOT CHG      PROV REIMB   PD DT     CAN DT    REAS NPC
#DAYS
  123456789D   XXXXXX           P O9998     XXX     0523XX    0523XX    0524XX
0603XX
                              3413.57                0617XX             XXXXX
  123456789D   XXXXXX            P O9998     XXX     0603XX    0603XX    0614XX
                              1305.00                0628XX             XXXXX
```

Revenue Codes (Option 13)

This option is helpful if you need to verify revenue codes that can be billed with specific bill types. This screen also provides information to verify what additional information (e.g., units, HCPCS code) must accompany the revenue code.

1. From the Inquiry Menu, type 13 in the **Enter Menu Selection** field and press Enter.

```
MAP1702                     CGS J15 MAC - HHH REGION              ACPFA052 XX/XX/XX
  XXXXXX                          INQUIRY MENU                    C201135E XX:XX:XX


        BENEFICIARY/CWF          10      ZIP CODE FILE             19

        DRG (PRICER/GROUPER)     11      OSC REPOSITORY INQUIRY    1A

        CLAIM SUMMARY            12      CLAIM COUNT SUMMARY       56

        REVENUE CODES            13      HOME HEALTH PYMT TOTALS   67

        HCPC CODES               14      ANSI REASON CODES         68

        DX/PROC CODES ICD-9      15      CHECK HISTORY             FI

        ADJUSTMENT REASON CODES  16      DX/PROC CODES ICD-10      1B

        REASON CODES             17

    ENTER MENU SELECTION: 13


      PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

You may also access this screen by typing **13** in the SC field if you are in an inquiry or claim entry screen.

2. The Revenue Code Table Inquiry screen (Map 1761) appears:

```
MAP1761                       CGS J15 MAC - Part A REGION              ACPFA052
MM/DD/YY
XXXXXX     SC                 REVENUE CODE TABLE INQUIRY             C201135E HH:MM:SS

              REV CD
EFF DT            IND                          TERM DT

NARR

          ALLOW:              HCPC:                UNITS:                RATE:
TOB         EFF-DT TRM-DT       EFF-DT TRM-DT        EFF-DT TRM-DT       EFF-DT TRM-DT
---       ---------------     ---------------      ---------------     ---------------
```


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3. To view revenue code information, type the revenue code in the **REV CD** field and press ***Enter***.

```
MAP1761                          CGS J15 MAC - Part A REGION          ACPFA052
XX/XX/XX
XXXXXX        SC            REVENUE CODE TABLE INQUIRY               C201135E
XX:XX:XX

                  REV CD 0420
EFF DT 070166         IND F                        TERM DT

NARR PHYSICAL THERAPY GENERAL CLASSIFICATION - PHYSICAL THERP

         ALLOW:              HCPC:               UNITS:               RATE:
TOB       EFF-DT TRM-DT       EFF-DT TRM-DT       EFF-DT TRM-DT       EFF-DT TRM-DT
---      ---------------     ---------------     ---------------     ---------------
11X      Y 070166            V                   N                   N
12X      Y 070166            Y 010199            Y 070198            N
13X      Y 070166            Y 010199            Y 070166            N
14X      N                   V                   N                   N
18X      Y 070166            V                   N                   N
21X      Y 070166            V                   N                   N
22X      Y 070166            Y 010199            Y 070198            N
23X      Y 070166            Y 010199            Y 070166            N
32X      Y 070166            Y 100199            Y 070166            N
33X      Y 070166            Y 100199            Y 070166            N

       PROCESS COMPLETED --- PLEASE CONTINUE
          PRESS PF3-EXIT  PF6-SCROLL FWD
```

To see all of the revenue code information for all types of bill (TOB), press ***F6*** to scroll forward.

4. To make additional inquiries, simply enter a new revenue code over the previously entered code and press ***Enter***. If you enter a new 3-digit revenue code over the previously entered code, the first digit must be a zero, or enter the 3-digit revenue code in the first 3 positions and delete the 4th digit before pressing ***Enter***.

5. Press ***F3*** to exit the Revenue Code Table Inquiry screen and return to the Inquiry Menu.

Field Descriptions – Option 13 Revenue Codes

Map 1761 Field Descriptions	
REV CD	Revenue code. A 4-digit field that represent the type of service, supply, or equipment being provided.
EFF DT	Effective date. The date the revenue code became effective (MMDDYY format).
IND	Effective date indicator. This date instructs the system to either use the “from” date of the claim or the system run date to perform edits for this revenue code. Values are: **F** Claim from date **R** Claim receipt date **D** Claim discharge date
TRM DT	Termination date. The date the revenue code became invalid. (MMDDYY format).
NARR	Narrative. The English-language description for the revenue code.
TOB	Type of bill. The first two digits of the type of bill followed by an ‘X’ denoting the frequency.
ALLOW:	Allowable. This field indicates whether the revenue code is valid for the type of bill. Values are: **Y** Yes **N** No
EFF-DT	Allowable effective date. The date the revenue code became a valid code (MMDDYY format).
TRM-DT	Allowable termination date. The date the revenue code was no longer valid (MMDDYY format).
HCPC:	Healthcare Common Procedure Code System. This field indicates whether the revenue code requires a HCPCS. Values are: **Y** Yes **N** No **V** Validation of HCPCS is required

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Map 1761 Field Descriptions	
EFF-DT	HCPCS effective date. The beginning date the HCPCS code became required for this revenue code (MMDDYY format).
TRM-DT	HCPCS termination date. The date the HCPCS code was no longer required for this revenue code (MMDDYY format).
UNITS:	Units required. This field indicates whether units must be entered for this revenue code. Values are: **Y** Yes **N** No
EFF-DT	Unit's effective date. The beginning date units became required for this revenue code (MMDDYY format).
TRM-DT	Unit's termination date. The date units were no longer required for this revenue code (MMDDYY format).
RATE:	Rate. This field indicates whether a rate must be entered for this revenue code. Values are: **Y** Yes **N** No Note: This field is currently not functional, and will always show "N".
EFF-DT	Rate's effective date. The beginning date for the requirement to enter a rate for this revenue code (MMDDYY format).
TRM-DT	Rate's termination date. The end date for the requirement to enter a rate for this revenue code (MMDDYY format).

HCPC Codes (Option 14)

This option is helpful if you need to inquire about Healthcare Common Procedure Coding System (HCPCS) code reimbursement or verify which revenue codes are allowable with HCPCS codes.

1. From the Inquiry Menu, type 14 in the **Enter Menu Selection** field and press ***Enter***.

```
MAP1702                          CGS J15 MAC - Part A REGION            ACPFA052
MM/DD/YY
XXXXXX                        INQUIRY MENU                           C201135E
HH:MM:SS


      BENEFICIARY/CWF           10    ZIP CODE FILE             19

      DRG (PRICER/GROUPER)      11    OSC REPOSITORY INQUIRY    1A

      CLAIM SUMMARY             12    CLAIM COUNT SUMMARY       56

      REVENUE CODES             13    HOME HEALTH PYMT TOTALS   67

      HCPC CODES                14    ANSI REASON CODES         68

      DX/PROC CODES ICD-9       15    CHECK HISTORY             FI

      ADJUSTMENT REASON CODES   16    DX/PROC CODES ICD-10      1B

      REASON CODES              17

  ENTER MENU SELECTION: 14


    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

You may also access this screen by typing ***14*** in the SC field if you are in an inquiry or claim entry screen.

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2. The HCPC Information Inquiry screen (Map 1771) appears:

```
MAP1771                        CGS J15 MAC - Part A REGION              ACPFA052
MM/DD/YY
XXXXXX     SC                   HCPC INFORMATION INQUIRY             C201135E
HH:MM:SS
                                                                        PAGE: 01
CARRIER          LOC       HCPC          MOD          IND
EFF DT           TRM DT              PROVIDER                  DRUG CODE

               E O F O C       ANES T M
EFF.    TRM.   F V E P A PC    BASE Y S
DATE    DATE   F R E H T TC    VAL  P I ALLOWABLE REVENUE CODES



HCPC DESCRIPTION


      PROCESS COMPLETED  ---   PLEASE CONTINUE
   PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

3. Use your Tab key to move to the **HCPC** field, and type the HCPCS code. Press ***Enter***. FISS will automatically insert information in the CARRIER and LOC fields based on your geographic location.

```
MAP1771                              CGS J15 MAC - Part A REGION        ACPFA052
MM/DD/YY
XXXXXX     SC                    HCPC INFORMATION  INQUIRY             C201135E
HH:MM:SS
                                                                        PAGE: 01
CARRIER XXXXX    LOC XX     HCPC 83970      MOD          IND R
EFF DT 010107    TRM DT               PROVIDER XXXXXX              DRUG CODE

               E O F O C       ANES T M
EFF.    TRM.   F V E P A PC    BASE Y S
DATE    DATE   F R E H T TC    VAL  P I ALLOWABLE REVENUE CODES

010114         F 3                     030X

010113         F 3                     030X

010112         F 3                     030X

010111         F 3                     030X



HCPC DESCRIPTION
Parathormone (parathyroid hormone) level
      PROCESS COMPLETED ---   PLEASE CONTINUE
    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

Use the following function keys to move around the screen:

F3 – Exit (return to the Inquiry Menu)
F5 – Scroll up one page
F6 – Scroll down one page
F11 – Scroll right
F10 – Scroll left

4. Press ***F11*** to move the screen to the right. Map 1772 will display. The type of data that displays will depend on the type of HCPCS code you enter. Press ***F10*** to move back to the left of Map 1771. Refer to the following for more information.

If the code is any other type of HCPCS code, Map 1772 will display the 60 percent, 62 percent, rehabilitation, and professional service rates. Press ***F10*** to move back to the right to Map 1771.

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```
MAP1772                              CGS J15 MAC - Part A REGION        ACPFA052
MM/DD/YY
XXXXXX      SC                     HCPC RATES  INQUIRY                 C201135E
HH:MM:SS
                                                                          PAGE:
02
  CARRIER XXXXX     LOC XX     HCPC 83704      MOD          IND

  EFF DT   TRM DT     60%RATE       62%/REDU          REHAB        PROF       NFACPE

  010109                46.070        47.610

  010108                44.080        45.550

  010107                44.080        45.550

  010106                44.080        45.550


  HCPC DESCRIPTION
LIPOPROTEIN, BLOOD; QUANTITATION OF LIPOPROTEIN PARTICLE NUMBERS AND
LIPOPROTEIN PARTICLE SUBCLASSES (EG, BY NUCLEAR MAGNETIC RESONANCE SPECTROSCO
```

5. To inquire about other HCPCS codes, enter the HCPCS code over the previously entered HCPC and press ***Enter***.
6. Press ***F3*** to exit the HCPCS Information Inquiry screen and return to the Inquiry Menu.

Field Descriptions for Option 14 – HCPC Codes

Map 1772 Field Descriptions	
CARRIER	Carrier. The carrier number assigned to your provider file. System generated.
LOC	The two position locality code which identifies the area where the provider is located.
HCPC	Healthcare Common Procedure Coding System. The HCPCS code to be reviewed on the screen.
MOD	HCPC Modifier. Multiple fees will be identified for the HCPCS code based on the modifier.
IND	HCPC indicator.
EFF DT	Effective date. The date the rate became effective (MMDDYY format).
TERM DT	Termination date. The termination date for the rate listed (MMDDYY format).
PROVIDER	The Medicare provider number assigned to your facility.
DRUG CODE	This field identifies whether the HCPCS code is a drug. The valid values are: **E** HCPCS is a drug **" "** HCPCS is not a drug
EFF. DATE	Effective date. The effective date for the rate listed (MMDDYY format).
TRM. DATE	Termination date. The termination date for the rate listed (MMDDYY format).
EFF	Effective date indicator. This indicator instructs the system to either use the 'from' and 'through' dates of the claim or the system run date to perform edits for this HCPCS. Values are: **F** Claim from date **R** Claim receipt date **D** Discharge date
OVR	Override code. This field instructs the system in applying the services towards deductible and coinsurance. Values are: **0** Apply deductible and coinsurance **1** Do not apply deductible **2** Do not apply coinsurance **3** Do not apply deductible or coinsurance **4** No need for total charges (used for multiple HCPCS for single revenue code centers) **5** Rural health clinic or comprehensive outpatient rehabilitation facility psychiatric **M** Employer group health plan (EGHP) (only used on the 0001 total line for Medicare Secondary Payer (MSP)) **N** Non-EGHP (only used on the 0001 total line for MSP) **Y** MSP cost avoided

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Map 1772 Field Descriptions	
FEE	Fee Indicator. The fee indicator received in the Physician Fee Schedule file. Valid values: **B** Bundled procedure **R** Rehab/Audiology Function Test/CORF Services **" "** Space
OPH	Outpatient Hospital Indicator. The outpatient hospital indicator received in the physician fee schedule abstract test file. Valid values: **0** Fee applicable in Hospital Outpatient Setting **1** Fee not applicable in Hospital Outpatient Setting **" "** Space
CAT	
PC/TC	Professional Component/Technical Component. Valid values are: **0** Pay the Health Professional Shortage Area (HPSA) bonus **1** Globally billed. Professional component for this service qualifies for the HPSA bonus payment **2** Professional component only, pay the HPSA bonus **3** Technical component only, do not pay the HPSA bonus **4** Global test only. Professional component of this service qualifies for the HPSA bonus payment **5** Incident codes, do not pay the HPSA bonus **6** Laboratory physician interpretation codes, pay the HPSA bonus **7** Physical therapy service, do not pay the HPSA bonus **8** Physician interpretation codes, pay the HPSA bonus **9** Concept of PC/TC does not apply, do not pay the HPSA bonus
ANES BASE VAL	Anesthesia base value. The anesthesia base values.
TYP	HCPCS Type. An 'M' indicator will display when the HCPCS associated with the revenue line originated from the Medicare physician fee schedule.
MSI	Multiple services indicator. The value of '5' identifies services that are subject to the multiple procedure payment reduction (MPPR).
ALLOWABLE REVENUE CODES	Allowable revenue codes. The allowable revenue codes this HCPCS code may use in billing. This is a four-position field. When the last digit shows an "X," each variable for that revenue code is allowable. If this field is blank, the system will allow a HCPCS code on any revenue code.
HCPC DESCRIPTION	HCPCS description. The English narrative description of the HCPCS code.

Map 1772 Field Descriptions	
60%RATE	60% reimbursement rate. The rate the system will use for calculating reimbursement for the HCPCS.
62% RATE or 62%/REDU	62% lab reimbursement rate. The rate the system will use for calculating reimbursement for the lab HCPCS. When the MSI field equals a '5', this field will dispay "62%/REDU" or the reduced therapy fee amount.
REHAB	Rehabilitation rate. The rate used by the system to calculate reimbursement for the HCPCS code for rehabilitation services billed.
PROF	Professional service rate. The rate used by the system to calculate reimbursement for the HCPCS code for professional services
NFACPE	Non-facility amount practice expense (PE) relative value units (RVUs). This field reflects the 20 percent reduction in non-facility PE RVUs.

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DX/Proc Codes ICD-9 (Option 15)

This option is helpful if you need to confirm the validity of diagnosis or procedure codes.

1. From the Inquiry Menu, type 15 in the **Enter Menu Selection** field and press ***Enter***.

```
MAP1702                          CGS J15 MAC - Part A REGION          ACPFA052
MM/DD/YY
XXXXXX                          INQUIRY MENU                        C201135E
HH:MM:SS


      BENEFICIARY/CWF           10    ZIP CODE FILE              19

      DRG (PRICER/GROUPER)      11    OSC REPOSITORY INQUIRY     1A

      CLAIM SUMMARY             12    CLAIM COUNT SUMMARY        56

      REVENUE CODES             13    HOME HEALTH PYMT TOTALS    67

      HCPC CODES                14    ANSI REASON CODES          68

      DX/PROC CODES ICD-9       15    CHECK HISTORY              FI

      ADJUSTMENT REASON CODES   16    DX/PROC CODES ICD-10       1B

      REASON CODES              17

  ENTER MENU SELECTION: 15


    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

You may also access this screen by typing **15** in the SC field if you are in an inquiry or claim entry screen.

2. The ICD-9-CM Code Inquiry screen (Map 1731) appears:

```
MAP1731                        CGS J15 MAC - Part A REGION              ACPFA052
MM/DD/YY
XXXXXX   SC            ICD-9-CM CODE INQUIRY                         C201135E
HH:MM:SS
STARTING  ICD9 CODE:

ICD9 CODE                        DESCRIPTION:
        EFFECTIVE/TERM DATE       EFFECTIVE/TERM DATE      EFFECTIVE/TERM DATE
```

3. **To inquire about a diagnosis code,** enter the diagnosis code in the **STARTING ICD9 CODE** field and press ***Enter***. Do not type the decimal point or zero-fill the code. To review a complete list of diagnosis codes, press ***Enter***.

While FISS enables you to validate diagnosis codes, you should still have a current ICD-9-CM coding book in your office.

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```
MAP1731                          CGS J15 MAC - Part A REGION          ACPFA052
XX/XX/XX
XXXXXX      SC              ICD-9-CM CODE INQUIRY                    C201135E
XX:XX:XX
STARTING    ICD9 CODE: 1630

ICD9 CODE                      DESCRIPTION:
          EFFECTIVE/TERM DATE     EFFECTIVE/TERM DATE    EFFECTIVE/TERM DATE
 1630       MAL NEO PARIETAL PLEURA
              100185 093012
 1631       MAL NEO VISCERAL PLEURA
              100185 093012
 1638       MALIG NEOPL PLEURA NEC
              100185 093012
 1639       MALIG NEOPL PLEURA NOS
              100185 093012
 1640       MALIGNANT NEOPL THYMUS
              100185 093012
 1641       MALIGNANT NEOPL HEART
              100185 093012
 1642       MAL NEO ANT MEDIASTINUM
              100185 093012
 1643       MAL NEO POST MEDIASTINUM
              100185 093012

 PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, PRESS PF3-EXIT, PF6-SCROLL FWD
```

If more than one of the same code is listed, be sure to review the description, effective and termination dates, and use the most current code that applies to the service dates on your claim.

Press ***F6*** to scroll forward through the list of diagnosis codes.

4. To make an additional inquiry, type the new diagnosis code over the previously entered diagnosis code and press ***Enter***.
5. **To inquire about a procedure code,** type the letter P followed by the procedure code in the STARTING ICD9 CODE field and press ***Enter***. To review a complete list of procedure codes, enter the letter ***P*** in the **STARTING ICD9 CODE** field and press ***Enter***.
6. Press ***F3*** to exit and return to the Inquiry Menu.

Field Descriptions for Option 15 – DX/PROC Codes ICD-9

Map 1731 Field Descriptions	
STARTING ICD9 CODE	ICD-9-CM code. The ICD-9-CM code identifying a specific diagnosis or procedure.
DESCRIPTION	ICD-9-CM description. The narrative for the ICD-9-CM code.
EFFECTIVE/TERM DATE	Effective/termination date. The effective and/or termination date for the ICD-9-CM code in MMDDYY format. (Up to three occurrences of dates can appear.)

Adjustment Reason Codes (Option 16)

This option allows you to view adjustment reason codes and their narratives. Use these codes to identify reasons for an adjustment. Adjustment reason codes must be submitted on adjustment and cancellation claims when using FISS to submit these type of billing transactions. See Chapter 5 of this guide for additional information about using FISS to submit adjustment and cancellation claims.

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1. From the Inquiry Menu, type ***16*** in the **Enter Menu Selection** field and press ***Enter***.

```
MAP1702                    CGS J15 MAC - Part A REGION            ACPFA052
MM/DD/YY
XXXXXX                     INQUIRY MENU                        C201135E HH:MM:SS


      BENEFICIARY/CWF          10    ZIP CODE FILE             19

      DRG (PRICER/GROUPER)     11    OSC REPOSITORY INQUIRY    1A

      CLAIM SUMMARY            12    CLAIM COUNT SUMMARY       56

      REVENUE CODES            13    HOME HEALTH PYMT TOTALS   67

      HCPC CODES               14    ANSI REASON CODES         68

      DX/PROC CODES ICD-9      15    CHECK HISTORY             FI

      ADJUSTMENT REASON CODES  16    DX/PROC CODES ICD-10      1B

      REASON CODES             17

   ENTER MENU SELECTION: 16


    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

You may also access this screen by typing **16** in the SC field if you are in an inquiry or claim entry screen.

2. The Adjustment Reason Codes Inquiry screen (Map 1821) appears:

```
MAP1821                    CGS J15 MAC - Part A REGION            ACPFA052
MM/DD/YY
XXXXXX      SC          ADJUSTMENT REASON CODES INQUIRY           C201135E
HH:MM:SS
                                SELECTION SCREEN            MNT:
 CLAIM TYPES:
 I = INPATIENT/SNF,   O = OUTPATIENT,    H = HOME HEALTH/CORF,    A = ALL CLAIMS
 PLAN CODE:           REASON CODE:
S PC RC HC TYPE                NARRATIVE
```

3. Press ***Enter*** to view a complete listing of adjustment reason codes on Map 1821, or type an adjustment reason code in the **REASON CODE** field and press ***Enter*** to display Map 1822.

On Map 1821, press ***F6*** to scroll forward through the list of adjustment reason codes. Press ***F5*** to scroll backwards.

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```
MAP1821                          CGS J15 MAC - Part A REGION          ACPFA052
XX/XX/XX
XXXXXX     SC              ADJUSTMENT REASON CODES INQUIRY          C201135E XX:XX:XX
                                    SELECTION SCREEN          MNT: XXXXXX  MMDDYY
CLAIM TYPES:
I = INPATIENT/SNF,  O = OUTPATIENT,  H = HOME HEALTH/CORF,  A = ALL CLAIMS
PLAN CODE: 1          REASON CODE:
S PC RC HC TYPE                          NARRATIVE
S  1  AA AA A This change is due to an automated adjustment.
   1  AC PI A AUDIT COMPLIANCE
   1  AD AD I This overpayment is a result of a Quality Improvement Organizati
   1  AH HF A ADJUSTMENTS TO DO FULL DENIAL ON PREVIOUSLY PAID CLAIM.
   1  AJ NN A HEARING REOPEN
   1  AM AM I This overpayment is a result of a Quality Improvement Organizati
   1  AP NW A HEARING PARTIAL
   1  AR AR I This claim adjustment is due to a review that reversed the
   1  AU AU A This overpayment is a result of a claim being processed with
   1  AW AW I An admission denial adjustment has been processed, however, the
   1  BB BB A This overpayment is a result of a same day transfer.
   1  BC BC A This overpayment is a result of the beneficiary file being
   1  BL BL A This overpayment is a result of a claim being processed with
   1  BP OR A PART B REVIEW PARTIAL
   1  BR OO A PART B REVIEW REOPEN
       PROCESS COMPLETED --- PLEASE CONTINUE
    PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, PRESS PF3-EXIT, PF6-SCROLL FWD
```

4. Type ***S*** in the **S** field to select a specific code. Press ***Enter*** to view Map 1822.

You can only select one code at a time.

```
MAP1822                          CGS J15 MAC - Part A REGION              ACPFA052
XX/XX/XX
XXXXXX     SC       ADJUSTMENT REASON CODE UPDATE SCRN INQUIRY    C201135E XX:XX:XX
                                                                  MNT: XXXXXX MMDDYY
CLAIM TYPES :
I = INPATIENT/SNF,  O = OUTPATIENT,  H = HOME HEALTH/CORF,  A = ALL CLAIMS

PLAN CODE:                 REASON CODE : AA        HIGLAS REASON CODE : AA

                           CLAIM TYPE : A

                           NARRATIVE
This change is due to an automated adjustment.


PRESS PF3-EXIT PF7-PREV PAGE
```

5. The Adjustment Reason Code Update Scrn Inquiry (Map 1822) appears. The difference between Map 1821 and Map 1822 is that Map 1822 allows you to see the full narrative.
6. Press ***F7*** to return to Map 1821.

Field Descriptions for Option 16 – Adjustment Reason Codes

Map 1821 Field Descriptions	
MNT:	Identifies your operator ID and today's date. For intermediary use only.
CLAIM TYPES:	Claim types. The claim types identified for each adjustment reason code. The claim types are: **I** Inpatient/SNF **O** Outpatient **H** Home Health/CORF **A** All Claims
PLAN CODE:	Plan Code. For intermediary use only.
REASON CODE:	Adjustment reason code. To review a particular adjustment reason code, enter the adjustment reason code value in this field. This field can be used instead of the S (selection) field described below.
S	Selection. This field is used to make a selection to view information for a particular adjustment reason code.

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Map 1821 Field Descriptions	
PC	Plan Code. For intermediary use only.
RC	Adjustment reason code. This field displays the adjustment reason codes.
HC	HIGLAS adjustment reason code. This field identifies the HIGLAS (Healthcare Integrated General Ledger Accounting System) adjustment reason code.
TYPE	Claim type. The type of claim associated with this reason code. (Refer to the "CLAIM TYPES" field, above, for valid values.)
NARRATIVE	Narrative. The description for the adjustment reason code.

Map 1822 Field Descriptions	
MNT:	Identifies the last operator who created or revised this screen and the date. For intermediary use only.
CLAIM TYPES:	The claim types identified for each adjustment reason code. Valid claim types are: **I** Inpatient/SNF **O** Outpatient **H** Home Health/CORF **A** All Claims
PLAN CODE:	Plan Code. For intermediary use only.
REASON CODE	Adjustment reason code identifying the reason for an adjustment.
HIGLAS REASON CODE	HIGLAS reason code. Used to crosswalk the FISS adjustment reason code to the HIGLAS adjustment reason code.
CLAIM TYPE	Claim type. The type of claim associated with this reason code. (Refer to the "CLAIM TYPES" field, above, for valid values.)
NARRATIVE	Narrative. The description for the adjustment reason code.

Reason Codes (Option 17)

The Reason Codes Inquiry screen provides an explanation/description of the reason code on your claim. **You will use this option often** to determine what actions are necessary to correct claims in the Return to Provider (RTP) file (T B9997). Rather than selecting option 17 from the Inquiry Menu, you will most likely access the reason codes by pressing F1 when you are in the Claims Entry or Claims Correction options in FISS.

1. From the Inquiry Menu, type ***17*** in the **Enter Menu Selection** field and press ***Enter***.

```
MAP1702                      CGS J15 MAC - Part A REGION              ACPFA052
MM/DD/YY
XXXXXX                      INQUIRY MENU                            C201135E
HH:MM:SS


     BENEFICIARY/CWF          10    ZIP CODE FILE             19

     DRG (PRICER/GROUPER)     11    OSC REPOSITORY INQUIRY    1A

     CLAIM SUMMARY            12    CLAIM COUNT SUMMARY       56

     REVENUE CODES            13    HOME HEALTH PYMT TOTALS   67

     HCPC CODES               14    ANSI REASON CODES         68

     DX/PROC CODES ICD-9      15    CHECK HISTORY             FI

     ADJUSTMENT REASON CODES  16    DX/PROC CODES ICD-10      1B

     REASON CODES             17

  ENTER MENU SELECTION: 17


    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```


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You may also access this screen by typing **17** in the SC field if you are in an inquiry or claim entry screen or by pressing ***F1*** while you are inquiring, entering or correcting a claim.

2. The Reason Codes Inquiry screen (Map 1881) appears:

```
MAP1881                        CGS J15 MAC - Part A REGION          ACPFA052
MM/DD/YY
XXXXXX     SC                REASON CODES INQUIRY                 C201135E HH:MM:SS
                                                                       MNT:
PLAN   REAS    NARR    EFF       MSN     EFF        TERM      EMC      HC/PRO    PP     CC
IND    CODE    TYPE    DATE      REAS    DATE       DATE      ST/LOC   ST/LOC    LOC    IND
 1              E
 TPTP    A      B     NPCD    A     B    HD CPY A    B     NB ADR        CAL DY       C/L
-----------------------------------NARRATIVE-----------------------------------------


      PLEASE ENTER DATE - OR PRESS PF3 TO EXIT
```

3. Enter the reason code in the **REAS CODE** field and press ***Enter***.

Reason codes are found at the bottom left corner of the FISS claim pages. Whenever a reason code appears on your claim, the easiest way to access it is to press your F1 key. Note that having a reason code present on your claim does not mean that it needs correction. For example, even when a claim is in a "P" (paid) status, FISS still assigns a reason code to the claim. Refer to the Chapter 5 of this guide to further understand when you need to correct a claim.

```
MAP1881                        CGS J15 MAC - Part A REGION          ACPFA052
MM/DD/YY
XXXXXX       SC             REASON CODES INQUIRY                  C201135E HH:MM:SS
                                                                     MNT: XXXXXX
MMDDYY
PLAN   REAS   NARR    EFF       MSN       EFF       TERM      EMC       HC/PRO    PP    CC
IND    CODE   TYPE    DATE      REAS      DATE      DATE      ST/LOC    ST/LOC    LOC   IND
 1     32402    E    052394                                   T         T
 TPTP   A      B     NPCD A      B      HD CPY A     B     NB ADR       CAL DY       C/L C
-----------------------------------NARRATIVE-----------------------------------------
HCPCS CODE REPORTED ON THIS CLAIM HAS NOT BEEN BILLED WITH A VALID
REVENUE CODE FOR THE DATES OF SERVICE.
VERIFY BILLING AND IF APPROPRIATE, CORRECT.
** ONLINE PROVIDERS:  PRESS PF9 TO STORE THE CLAIM.
** OTHER  PROVIDERS:  RETURN TO THE INTERMEDIARY.

 PROCESS COMPLETED --- PLEASE CONTINUE
 PRESS PF3-EXIT     PF6-SCROLL FWD      PF8-NEXT
```

NOTE: Please note that you may need to press ***F6*** to scroll forward to see all of the reason code narrative.

4. To see the ANSI reason code that corresponds to the FISS reason code press your F8 key. The ANSI Related Reason Codes Inquiry screen (Map 1882) appears.

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```
MAP1882                              CGS J15 MAC - Part A REGION        ACPFA052
MM/DD/YY
XXXXXX      SC          ANSI RELATED REASON CODES INQUIRY          C201135E HH:MM:SS
                                                                  MNT: XXXXXX MMDDYY

REASON CODE: 38107
PIMR ACTIVITY CODE:                  DENIAL CODE:                      MR INDICATOR:
                                     PCA INDICATOR:                    LMRP/NCD ID :
ANSI CODES
  ADJ REASONS :   107

  GROUPS      :   CO


  REMARKS     :   M1

  APPEALS (A) :   MA02

  APPEALS (B) :   MA01

  CATEGORY    :   EMC P1                    HC P1

  STATUS      :   EMC 0020                  HC 0020

           PRESS PF3-EXIT PF7-PREV PAGE
```

Field Descriptions for Option 17 – Reason Codes

Map 1881 Field Descriptions	
MNT:	Identifies the last operator who created or revised this screen and the date. For intermediary use only.
PLAN IND	Plan indicator. For intermediary use only.
REAS CODE	Reason code. The reason code identifies a specific condition assigned to the claims during processing. The following identifies the meaning of the first digit of the reason code.

First Digit of Reason Code	Meaning	Example
1	Consistency Edits	11801 (missing/invalid point of origin, previously known as source of admission)
3	FISS	37402 (claims not submitted sequentially) 38107 (system cannot match final claim to processed RAP)
5	Medical Review	56900 (no response to additional development request)

NARR TYPE	Narrative type. An “E” indicates the narrative is for external users.
EFF DATE	Effective date. The effective date of the reason code.
MSN REAS	Medicare Summary Notice Reason. If a denial is made on the claim, the denial reason code in this field generates the narrative for the Notes section of the Medicare Summary Notice (MSN).
EFF DATE	Effective Date. The effective date for the alternate reason.
TERM DATE	Termination Date. The termination date for the alternate reason.
EMC ST/LOC	Electronic media claims status and location. The status and location set up for automated claims that encounter the reason code. If this field is blank, the HC/PRO ST/LOC field will apply.
HC/PRO ST/LOC	Hardcopy/Quality Improvement Organization (QIO) Status/Location. The status and location set up for hardcopy or QIO claims, which encounter the reason code.
PP LOC	Post-pay location. This field identifies the post-pay location for postpay development activities.
CC IND	Clean claim indicator. This field instructs the system whether to pay interest. Values are: **A** PIP other. **B** PIP clean. **C** Non-PIP other. **D** Non-PIP clean. **E** Additional information was requested (non-PIP). **F** Additional information was requested (PIP).

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Map 1881 Field Descriptions	
CC IND (continued)	**G** A reply was received from the Common Working File (CWF) providing a date of death, which required development in order to process the claim (non-PIP). **H** A reply was received from CWF providing a date of death, which required development in order to process the claim (PIP). **I** A non-definitive response was received from CWF requiring development (non-PIP). **J** A non-definitive response was received from CWF requiring development (PIP). **K** A definitive response was not received from CWF within 7 days (delayed response) (non-PIP). **L** A definitive response was not received from CWF within 7 days (delayed response) (PIP). **M** The claim was manually set to non-clean. This will only occur in rare situations such as a claim requiring development external to the intermediary's operation (non-PIP). **N** The claim was manually set to non-clean. This will only occur in rare situations such as a claim requiring development external to the intermediary's operation (PIP). **O** The claim is a sequential claim in which the prior claim was pending (non-PIP). **P** The claim is a sequential claim in which the prior claim was pending (PIP).
TPTP A - B	For intermediary use only.
NPCD A - B	For intermediary use only.
HD CPY A - B	For intermediary use only.
NB ADR	For intermediary use only.
CAL DY	For intermediary use only.
C/L	For intermediary use only.
NARRATIVE	Narrative for the specific reason code.

Map 1882 Field Descriptions	
MNT:	Identifies the last operator who created or revised this screen and the date. For intermediary use only.
REASON CODE:	Reason code. The reason code identifies a specific condition assigned to the claims during processing.
PIMR ACTIVITY CODE:	Program integrity management reporting (PIMR) activity code. The PIMR activity code for which the reason code is being categorized. Valid values are: **AI** Automated CCI edit **AL** Automated locally developed edit **AN** Automated national edit **CP** Prepay complex probe review **DB** TPL or demand bill claim review **MR** Manual routine review **PS** Prepay complex provider specific review **RO** Reopening **SS** Prepay complex service specific review
DENIAL CODE:	PIMR denial reason code. The denial reason code for which the reason code is being categorized. Valid values are: **100001** Documentation Does Not Support Service **100002** Investigation/Experimental **100003** Item/Services Excluded From Medicare Coverage **100004** Requested Information Not Received **100005** Services Not Billed Under The Appropriate Revenue Or Procedure Code (Include Denials Due To Unbundling In This Category **100006** Services Not Documented In Record **100007** Services Not Medically Reasonable And Necessary **100008** Skilled Nursing Facility Demand Bills **100009** Daily Nursing Visits Are Not Intermittent/ Part Time **100010** Specific Visits Did Not Include Personal Care Service **100011** Home Health Demand Bills **100012** Ability To Leave Home Unrestricted **100013** Physician's Order Not Timely **100014** Service Not Ordered/Not Included In Treatment Plan

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Map 1882 Field Descriptions	
DENIAL CODE (continued):	**100015** Services Not Included In Plan Of Care **100016** No Physician Certification (E.G. Home Health) **100017** Incomplete Physician Order **100018** No Individual Treatment Plan **100019** Other
MR INDICATOR:	Complex manual medical review. Identifies whether the service received complex manual medical review. Valid values are: **" "** The services did not receive manual medical review. **Y** Medical records received. This service received complex manual medical review. **N** Medical records were not received. This service received routine manual medical review
PCA INDICATOR	Progressive Correction Action. Identifies the progressive correction action indicator. Valid values are: **" "** The medical policy parameter is not PCA-related and is not included in the PCA transfer files. **Y** The medical policy parameter is PCA-related and is included in the PCA transfer files. **N** The medical policy parameter is not PCA-related and is not included in the PCA transfer files.
LMRP/NCD ID:	Local medical review policy (LMRP) (currently known as local coverage determination (LCD)) and/or national coverage determination (NCD) identification number. The LMRP/NCD ID number that are assigned to the FMR reason code for reporting on the Medicare Summary Notice. Intermediary/CMS defined.
ADJ REASONS	Adjustment reasons. This field provides the American National Standards Institute (ANSI) code that explains why an adjustment is being processed.
GROUPS	Groups. This field provides the ANSI code indicating the financial responsibility for the amount of the adjustment or identifies a postinitial adjudication adjustment in the X12 835 case segment. The five group codes are: **PR** Patient responsibility **CO** Contractual obligations **OA** Other adjustment **CR** Correction to or reversal of a prior decision **96** Noncovered charges
REMARKS	Remarks. This field provides the ANSI code that identifies the reason for non-payment. This is a five-position alphanumeric field, with four occurrences.
APPEALS (A)	Appeals (A). This field provides the ANSI code indicating the appeal rights related to the initial Part A determination.
APPEALS (B)	Appeals (B). This field provides the ANSI code indicating the appeal rights related to the initial Part B determination. Not applicable to hospice.
EMC CATEGORY	Electronic media claim category code. This field provides the ANSI code that identifies the EMC category of the claim returned on a 277 claim status response.
HC CATEGORY	Hard copy claim category code. This field provides the ANSI code that identifies the hard copy category of the claim returned on a 277 claim status response.
EMC STATUS	Electronic media claim status code. This field provides the ANSI code that identifies the EMC status of the claim returned on a 277 claim status response.
HC STATUS	Hard copy claim status code. This field provides the ANSI code that identifies the hard copy status of the claim returned on a 277 claim status response.

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Zip Code File (Option 19)

This option is applicable to ambulance providers. It provides the geographic area definitions (rural, urban, and super rural) by zip code and by state.

1. From the Inquiry Menu, type ***19*** in the **Enter Menu Selection** field and press ***Enter***.

```
MAP1702                        CGS J15 MAC - Part A REGION          ACPFA052
MM/DD/YY
XXXXXX                      INQUIRY MENU                          C201135E HH:MM:SS


      BENEFICIARY/CWF          10    ZIP CODE FILE             19

      DRG (PRICER/GROUPER)     11    OSC REPOSITORY INQUIRY    1A

      CLAIM SUMMARY            12    CLAIM COUNT SUMMARY       56

      REVENUE CODES            13    HOME HEALTH PYMT TOTALS   67

      HCPC CODES               14    ANSI REASON CODES         68

      DX/PROC CODES ICD-9      15    CHECK HISTORY             FI

      ADJUSTMENT REASON CODES  16    DX/PROC CODES ICD-10      1B

      REASON CODES             17

  ENTER MENU SELECTION: 19

    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

OSC Repository Inquiry (Option 1A)

This option is used to retain the history of all Occurrence Span Codes (OSCs) billed by Long Term Care Hospital (LTCH), Inpatient Psychiatric Facility (IPF), and Inpatient Rehabilitation Facility (IRF) providers.

1. From the Inquiry Menu, type ***1A*** in the **Enter Menu Selection** field and press ***Enter***.

```
MAP1702                        CGS J15 MAC - Part A REGION          ACPFA052
MM/DD/YY
XXXXXX                      INQUIRY MENU                          C201135E HH:MM:SS


      BENEFICIARY/CWF          10    ZIP CODE FILE             19

      DRG (PRICER/GROUPER)     11    OSC REPOSITORY INQUIRY    1A

      CLAIM SUMMARY            12    CLAIM COUNT SUMMARY       56

      REVENUE CODES            13    HOME HEALTH PYMT TOTALS   67

      HCPC CODES               14    ANSI REASON CODES         68

      DX/PROC CODES ICD-9      15    CHECK HISTORY             FI

      ADJUSTMENT REASON CODES  16    DX/PROC CODES ICD-10      1B

      REASON CODES             17

  ENTER MENU SELECTION: 1A

    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```


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Claim Count Summary (Option 56)

This option provides a summary of all of your facility's billing transactions that are currently processing within FISS by status/location and type of bill. This option will assist you in getting a quick picture of where all of your processing claims are located in FISS. CGS recommends that you check option 56 when you first sign into FISS for the day. This screen is only updated in the evening, Monday through Friday. By reviewing option 56, you can easily identify if there are claims:

- On the payment floor (P B9996), which means your claim has been approved for payment;
- In an Additional Development Request (ADR) status (S B6001), which means that CGS has requested that you submit additional information; or
- In a Return to Provider (RTP) status (T B9997), which means that the claim needs to be corrected by your facility.

1. From the Inquiry Menu, type ***56*** in the **Enter Menu Selection** field and press ***Enter***.

```
MAP1702                        CGS J15 MAC - Part A REGION          ACPFA052
MM/DD/YY
XXXXXX                      INQUIRY MENU                          C201135E HH:MM:SS


      BENEFICIARY/CWF          10    ZIP CODE FILE             19

      DRG (PRICER/GROUPER)     11    OSC REPOSITORY INQUIRY    1A

      CLAIM SUMMARY            12    CLAIM COUNT SUMMARY       56

      REVENUE CODES            13    HOME HEALTH PYMT TOTALS   67

      HCPC CODES               14    ANSI REASON CODES         68

      DX/PROC CODES ICD-9      15    CHECK HISTORY             FI

      ADJUSTMENT REASON CODES  16    DX/PROC CODES ICD-10      1B

      REASON CODES             17

  ENTER MENU SELECTION: 56


    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

You may also access this screen by typing ***56*** in the SC field if you are in an inquiry or claim entry screen.

2. The Claim Summary Totals Inquiry screen (Map 1371) appears:

```
MAP1371                          CGS J15 MAC - Part A REGION        ACPFA052
MM/DD/YY
XXXXXX      SC            CLAIM SUMMARY TOTALS INQUIRY            C201135E HH:MM:SS

      PROVIDER                        S/LOC          CAT
      NPI
S/LOC       CAT     CLAIM COUNT         TOTAL CHARGES          TOTAL PAYMENT

PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
 PRESS PF3-EXIT         PF5-SCROLL BKWD        PF6-SCROLL FWD
```

3. To obtain the summary of billing transactions, press ***Enter***.

If you are authorized to view other provider number information (branch office), you will have access to the PROVIDER field to enter another provider number.

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You may also enter a specific status/location (e.g., T B9997) in the S/LOC field, or a category type in the CAT field to narrow the selection.

```
MAP1371                        CGS J15 MAC - Part A REGION          ACPFA052
MM/DD/YY
XXXXXX      SC         CLAIM SUMMARY TOTALS INQUIRY              C201135E HH:MM:YY

         PROVIDER NNNNNN            S/LOC           CAT
         NPI NNNNNNNNNN

S/LOC          CAT     CLAIM COUNT     TOTAL CHARGES     TOTAL PAYMENT
               GT            49          48,389.34          5,722.00
P B7501        TC             9           9,768.85              00.00
P B7501        13             9           9,768.85              00.00
P B7505        TC            20          22,767.48              00.00
P B7505        12             5           4,099.80              00.00
P B7505        11            15          18,667.68              00.00
P B9996        TC             6           6,921.11          5,722.00
P B9996        11             6           6,921.11          5,722.00
S B90M0        TC             1              00.00              00.00
S B90M0        32             1              00.00              00.00
S B6001        TC             2           1,761.70              00.00
S B6001        13             1             761.70              00.00
S B6001        11             1           1,000.00              00.00
T B9997        NM            11           7,170.20              00.00
T B9997        TC            11           7,170.20              00.00
T B9997        11            11           7,170.20              00.00

        PROCESS COMPLETED --- PLEASE CONTINUE
PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, PRESS PF3-EXIT, PF6-SCROLL FWD
```

4. Once the information is displayed, you can identify where your claims are within FISS by looking at the **S/LOC** field. Option 56 identifies how many claims are in a particular status/location. The CAT column identifies the first two digits of the type of bill and the category code for each specific status/location. The CLAIM COUNT column provides the number of claims in that specific status/location. Refer to the field description for a complete list of CAT codes. You may need to press F6 to see the complete list of status/locations.

- In the screen example above, this provider can quickly identify:
  - There are a grand total (GT) of 49 claims for a total charge of $48,389.34 and payment amount of $5,722.00 (payment floor status/location P B9996).
  - The status/location P B9996 (payment floor) has a total count (TC) of six claims. The six claims have a total charge of $6,921.11 and a total payment of $5,722.00. All six claims are type of bill (TOB) 13X (CAT code 13).
  - The status/location S B6001 (Additional Development Request (ADR) status) has a total count (TC) of two claims. One of the claims is a TOB 12X; and one is a TOB 13X (CAT codes 12 and 13).
  - The status/location T B9997 (Return to Provider (RTP) status) has a total count (TC) of 11 claims. All claims are TOB 13X (CAT code 13) and all were placed in RTP because of clerical errors (CAT code NM).
- Option 56 only displays claims that are currently processing in FISS. Claims that are finalized in the system (i.e., with status/locations of R B9997, P B9997, D B9997) are not included within this option. In addition, option 56 only displays claims by status/location code. You can use option 56 in conjunction with option 12 if you want to identify *which* claims are in a particular status/location code.

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If you want to know specifically which six claims are in P B9996, press ***F3*** to exit option 56. Select 12 (Claims) from the Inquiry Menu and press ***Enter***. Type your facility's NPI number in the **NPI** field, then tab to the **S/LOC** field and enter P B9996. Press ***Enter***. All the claims for your facility that are in status/location P B9996 will appear. See below. Remember that you may need to press ***F6*** to scroll forward to see all claims.

```
MAP1741                      CGS J15 MAC - Part A REGION          ACPFA052
MM/DD/YY
XXXXXX     SC          CLAIM SUMMARY INQUIRY                  C201135E HH:MM:SS
                           NPI XXXXXXXXXX
    HIC                PROVIDER                      S/LOC P B9996   TOB
OPERATOR ID XXXXXXXXXX  FROM DATE       TO DATE                   DDE SORT
MEDICAL REVIEW SELECT
      HIC           PROV/MRN  S/LOC       TOB     ADM DT  FRM DT  THRU  DT  REC DT
SEL   LAST NAME   FIRST INIT  TOT CHG   PROV REIMB  PD DT  CAN DT REAS NPC #DAYS
  NNNNNNNNNA XXXXXX          P B9996      131    0805XX 0801XX   0831XX   1006XX
    LASTNAME            A   1203.00       1008.00   1103XX         37186

  NNNNNNNNNB XXXXXX          P B9996      131      0807XX 0801XX 0831XX   1006XX
    LASTNAME            B   1500.00        896.00   1103XX         37186

  NNNNNNNNND XXXXXX          P B9996      131    1101XX 1101XX   1130XX   0202XX
    LASTNAME            C   1653.00       1400.00   0302XX         37186

  NNNNNNNNNA XXXXXX          P B9996      131    1001XX 1001XX   1031XX   0202XX
    LASTNAME            D    795.00        392.00   0301XX         37186

  NNNNNNNNNA XXXXXX          P B9996      131    1001XX 1001XX   1028XX   0212XX
    LASTNAME            E   1512.00       1120.00   0311XX         37186
     PROCESS COMPLETED --- PLEASE CONTINUE
PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, PRESS PF3-EXIT, PF6-SCROLL FWD
```

- When you view option 56, pay particular attention to whether you have claims in status/locations S B6001 and T B9997. These two status/locations require that you take action.
  - Claims in S B6001 require that you submit the information being requested via the ADR. Select option 12 (Claims) from the Inquiry Menu to determine which claims were selected, and what documentation you need to submit to respond to the ADR. For information about identifying and responding to ADRs, refer to the "Claims (Option 12)" information found earlier in this chapter.
  - Claims in the RTP status/location, T B9997, require that you make the necessary corrections to the claims. Select 03 (Claims Correction) from the Main Menu to correct claims.
- The TOTAL PAYMENT column identifies the payment amount for those claims that have been approved for payment (on the payment floor) and are in status/location (P B9996).
- Option 56 updates when the system cycle runs each night, Monday through Friday. Therefore, if option 56 indicates that you have two claims to correct, and you immediately correct both claims, option 56 will continue to indicate that you have two claims to correct until the screen updates during the nightly cycle. Please note that nightly cycles do not typically run on Federal holidays.
- After suppressing the view of a claim, it will no longer display in the RTP file; however, when viewing Claim Count Summary (option 56) or the Claim Inquiry (option 12) screens, the claim may still appear in status/location T B9997 for several weeks, until FISS purges suppressed claims to the "I" status.

5. Once you have reviewed the information on option 56, press ***F3*** to exit and return to the Inquiry Menu. You can then select 12 (Claims) from the Inquiry Menu to view the specific claims within each status/location.

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Field Descriptions for Option 56 - Claim Count Summary

Map 1371 Field Descriptions	
PROVIDER	Your Provider Transaction Access Number (PTAN).
S/LOC	Status/Location. Enter a specific status/location code in this field to view the number of billing transactions in that specific status/location. CGS suggests leaving this blank so you can see the status/locations of all the billing transactions currently processing.
CAT	Category. Enter a specific category (GT, TC, 13, 11, 72, or 74) to view the number of billing transaction under that specific category. CGS suggests leaving this blank so you can see all claims currently processing. See below for the valid CAT codes.
NPI	Your facility's National Provider Identifier (NPI) number.
S/LOC	This identifies the current status/location of the claims
CAT	The Category field identifies different items within the list. Valid values are: **##** – First two digits of the type of bill **GT** – Grand total of claims currently in process. **TC** – Total count of claims in a particular status/location. **AD** – An adjustment **NM** – Non-medical indicates the claim was placed in RTP because of a clerical error. **MP** – Medical policy indicates the claim was placed in RTP because of nonclerical error.
CLAIM COUNT	The total claim count for each specific status/location.
TOTAL CHARGES	The total dollar amount of charges submitted by the provider for the total number of claims identified in the claim count.
TOTAL PAYMENT	The total dollar payment amount calculated by the system. An amount will only show in this column for claims on the payment floor (P B9996).

ANSI Reason Codes (Option 68)

This option allows you to view the narrative for the ANSI (American National Standards Institute) codes. ANSI reason codes appear on remittance advices, and provide additional information, such as provider appeal rights and claims processing determinations.

1. From the Inquiry Menu, type 68 in the **Enter Menu Selection** field and press ***Enter***.

```
MAP1702                        CGS J15 MAC - Part A REGION          ACPFA052
MM/DD/YY
XXXXXX                      INQUIRY MENU                          C201135E HH:MM:SS


      BENEFICIARY/CWF          10    ZIP CODE FILE             19

      DRG (PRICER/GROUPER)     11    OSC REPOSITORY INQUIRY    1A

      CLAIM SUMMARY            12    CLAIM COUNT SUMMARY       56

      REVENUE CODES            13    HOME HEALTH PYMT TOTALS   67

      HCPC CODES               14    ANSI REASON CODES         68

      DX/PROC CODES ICD-9      15    CHECK HISTORY             FI

      ADJUSTMENT REASON CODES  16    DX/PROC CODES ICD-10      1B

      REASON CODES             17

  ENTER MENU SELECTION: 68


    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

You may also access this screen by typing ***68*** in the SC field if you are in an inquiry or claim entry screen.

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2. The ANSI Standard Codes Inquiry screen (Map 1581) appears:

```
MAP1581                      CGS J15 MAC - Part A REGION            ACPFA052
MM/DD/YY
XXXXXX    SC             ANSI STANDARD CODES SEL INQUIRY        C201135E HH:MM:SS

  RECORD TYPE:
  C = ADJ REASONS    G = GROUPS    R = REMARKS    A = APPEALS
  STANDARD CODE:                   T = CLAIM CATEGORY   S = CLAIM STATUS
  S RT CODE TERM DT                   NARRATIVE



    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

3. Type a record type, (A, C, G, R, S, or T) in the **RECORD TYPE** field and press ***Enter*** to display the ANSI reason codes for that particular record type

A = Appeals	**C** = Adjustment reason	**G** = Groups
R = Reference remarks	**S** = Claim status	**T** = Claim category

4. Press ***F6*** to page forward through the various ANSI reason codes. Press ***F5*** to scroll backwards.

```
MAP1581                            CGS J15 MAC - Part AREGION     ACPFA052 MM/DD/YY
XXXXXX    SC              ANSI STANDARD CODES SEL INQUIRY       C201135E HH:MM:SS

 RECORD TYPE: A
 C = ADJ REASONS   G = GROUPS    R = REMARKS    A = APPEALS
 STANDARD CODE:                  T = CLAIM CATEGORY   S = CLAIM STATUS
 S RT CODE TERM DT                  NARRATIVE
    A MA01          IF YOU DISAGREE WITH WHAT WE APPROVED FOR THESE SERVICES, Y
    A MA02          IF YOU DO NOT AGREE WITH THIS DETERMINATION, YOU HAVE THE R
    A MA04  110407  SECONDARY PAYMENT CANNOT BE CONSIDERED WITHOUT THE IDENTITY
    A MA05  101603  INCORRECT ADMISSION DATE, PATIENT STATUS OR TYPE OF BILL EN
    A MA06  080104  INCORRECT BEGINNING AND/OR ENDING DATE(S) ON CLAIM.
    A MA07  110407  THE CLAIM INFORMATION HAS ALSO BEEN FORWARDED TO MEDICAID F
    A MA08  110407  YOU SHOULD ALSO SEND THIS CLAIM TO THE PATIENT'S OTHER INSU
    A MA09  110407  CLAIM SUBMITTED AS UNASSIGNED BUT PROCESSED AS ASSIGNED. YO
    A MA10  110407  THE PATIENT'S PAYMENT WAS IN EXCESS OF THE AMOUNT OWED. YOU
    A MA100 110407  DID NOT COMPLETE OR ENTER ACCURATELY THE DATE OF CURRENT IL
    A MA101 110407  DID NOT COMPLETE OR ENTER ACCURATELY THE DATES PATIENT WAS
    A MA102 080104  DID NOT COMPLETE OR ENTER ACCURATELY THE REFERRING/ORDERING
    A MA103 110407  OUR RECORDS INDICATE THAT ONE OR MORE OF THE MEDICAL SERVIC
    A MA104 013104  DID NOT COMPLETE OR ENTER ACCURATELY THE DATE THE PATIENT W
    A MA105 060205  OUR RECORDS INDICATE THAT ONE OR MORE OF A NOT OTHERWISE CL
        PROCESS COMPLETED  ---   PLEASE CONTINUE
   PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, PRESS PF-3-EXIT, PF6-SCROLL FWD
```

5. Type ***S*** in the **S** field to view the entire narrative for the ANSI reason code and press ***Enter***.

```
MAP1581                          CGS J15 MAC - Part A REGION         ACPFA052 MM/
DD/YY
XXXXXX    SC             ANSI STANDARD CODES SEL INQUIRY           C201135E
HH:MM:SS

 RECORD TYPE:
 C = ADJ REASONS   G = GROUPS    R = REMARKS    A = APPEALS
 STANDARD CODE:                  T = CLAIM CATEGORY   S = CLAIM STATUS
 S RT CODE TERM DT                  NARRATIVE
   A MA01          IF YOU DISAGREE WITH WHAT WE APPROVED FOR THESE SERVICES, Y
 S A MA02          IF YOU DO NOT AGREE WITH THIS DETERMINATION, YOU HAVE THE R
   A MA04  110407 SECONDARY PAYMENT CANNOT BE CONSIDERED WITHOUT THE IDENTITY
   A MA05  101603 INCORRECT ADMISSION DATE, PATIENT STATUS OR TYPE OF BILL EN
   A MA06  080104 INCORRECT BEGINNING AND/OR ENDING DATE(S) ON CLAIM.
   A MA07  110407 THE CLAIM INFORMATION HAS ALSO BEEN FORWARDED TO MEDICAID F
   A MA08  110407 YOU SHOULD ALSO SEND THIS CLAIM TO THE PATIENT'S OTHER INSU
   A MA09  110407 CLAIM SUBMITTED AS UNASSIGNED BUT PROCESSED AS ASSIGNED. YO
   A MA10  110407 THE PATIENT'S PAYMENT WAS IN EXCESS OF THE AMOUNT OWED. YOU
   A MA100 110407 DID NOT COMPLETE OR ENTER ACCURATELY THE DATE OF CURRENT IL
```


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6. The ANSI Standard Reason Codes Inquiry screen (Map 1582) appears.

```
MAP1582                     CGS J15 MAC - Part A REGION            ACPFA052
MM/DD/YY
XXXXXX     SC       ANSI STANDARD REASON CODES INQUIRY          C201135E HH:MM:SS
                                                                MNT: SYSTEM
07/02/10

  RECORD TYPES ARE:
 C = ADJ REASONS    G = GROUPS    R = REMARKS    A = APPEALS
                                  T = CLAIM CATEGORY S = CLAIM STATUS
                            RECORD TYPE    : A         TERM DT   :
                                                       EFF DT    :  010197
                            STANDARD CODE : MA02

                            NARRATIVE:

  IF YOU DO NOT AGREE WITH THIS DETERMINATION, YOU HAVE THE RIGHT TO
  APPEAL.  YOU MUST FILE A WRITTEN REQUEST FOR AN APPEAL WITHIN 180 DAYS
  OF THE DATE YOU RECEIVE THIS NOTICE.

        PRESS PF-3-EXIT, PF7-PREV PAGE
```

7. Press ***F7*** to return to Map 1581.

8. **To display one specific ANSI code**, type the appropriate record type (e.g., A, C, G, R, S, or T) in the **RECORD TYPE** field. Type the ANSI Standard Code that you wish to view in the **STANDARD CODE** field and press ***Enter***. The Map 1582 will display.

```
MAP1581                          CGS J15 MAC - Part A REGION       ACPFA052
MM/DD/YY
XXXXXX     SC                 ANSI STANDARD CODES SEL INQUIRY    C201135E  HH:MM:SS

 RECORD TYPE: C
 C = ADJ REASONS    G = GROUPS    R = REMARKS    A = APPEALS
 STANDARD CODE: B1               T = CLAIM CATEGORY  S = CLAIM STATUS
 S RT CODE TERM DT                  NARRATIVE
```

```
MAP1582                      CGS J15 MAC - Part A REGION            ACPFA052
MM/DD/YY
 XXXXXX     SC             ANSI STANDARD REASON CODES INQUIRY     C201135E HH:MM:SS
                                                                 MNT: SYSTEM      MM/DD/
YY
   RECORD TYPES ARE:
 C = ADJ REASONS    G = GROUPS    R = REMARKS    A = APPEALS
                                  T = CLAIM CATEGORY S = CLAIM STATUS
                            RECORD TYPE    : C         TERM DT   :
                                                       EFF DT    :  010195
                            STANDARD CODE : B1

                            NARRATIVE:

   NON-COVERED VISITS.
```

Field Descriptions for Option 68 – ANSI Reason Codes

Map 1581 Field Descriptions	
RECORD TYPE	The record type for the ANSI standard code. Valid values are: **A** Appeals **G** Groups **S** Claim Status **C** Adjustment Reasons **R** Reference Remarks **T** Claim Category
STANDARD CODE	The standard code within the above record type.
S	The selection field used to view the entire narrative of a specific ANSI code.
RT	The record type of the ANSI code being selected.
CODE	The ANSI code being selected.

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Map 1581 Field Descriptions	
TERM DT	The date that the ANSI code was deactivated. (MMDDYY)
NARRATIVE	The description of the ANSI code.

Map 1582 Field Descriptions	
MNT:	Identifies the last operator who created or revised his screen and the date. For intermediary use only.
RECORD TYPE	The record type for the ANSI code.
STANDARD CODE	The ANSI code within the above record type.
NARRATIVE	The description of the ANSI code.

Check History (Option FI)

This option identifies the three most recent Medicare payments issued to your facility.

1. From the Inquiry Menu, type ***FI*** in the **Enter Menu Selection** field and press ***Enter***.

```
MAP1702                        CGS J15 MAC - Part A REGION          ACPFA052
MM/DD/YY
XXXXXX                       INQUIRY MENU                      C201135E HH:MM:SS


      BENEFICIARY/CWF          10    ZIP CODE FILE             19

      DRG (PRICER/GROUPER)     11    OSC REPOSITORY INQUIRY    1A

      CLAIM SUMMARY            12    CLAIM COUNT SUMMARY       56

      REVENUE CODES            13    HOME HEALTH PYMT TOTALS   67

      HCPC CODES               14    ANSI REASON CODES         68

      DX/PROC CODES ICD-9      15    CHECK HISTORY             FI

      ADJUSTMENT REASON CODES  16    DX/PROC CODES ICD-10      1B

      REASON CODES             17

  ENTER MENU SELECTION: FI


    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

2. The Check History screen (Map 1B01) appears.
3. To view current check history, type your:
   - National Provider Identifier (NPI) in the **NPI** field; ***or***
   - Provider Transaction Access Number (PTAN) in the **PROV** field **and** your **NPI** in the NPI field.

NOTE: If you enter only your facility's PTAN in the **PROV** field, only check history from 2008 will display.

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```
MAP1B01                    CGS J15 MAC - Part A REGION        ACPFA052 MM/DD/YY
XXXXXX    SC                     CHECK HISTORY               C201135E HH:MM:SS


                          PROV                    NPI NNNNNNNNNN

                          CHECK #     DATE       AMOUNT



     PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

4. Press ***Enter*** to see check history for the three most recent reimbursements that were distributed to your facility either by check or Electronic Funds Transfer (EFT). The PTAN will display in the PROV field, after you type the NPI in the NPI field and press ***Enter***.

```
MAP1B01                    CGS J15 MAC - Part A REGION        ACPFA052 03/23/12
XXXXXX    SC                     CHECK HISTORY               C201135E HH:MM:SS


                          PROV  XXXXXX            NPI NNNNNNNNNN

                          CHECK #      DATE       AMOUNT

                          EFT2223333   YY1024        $916.56
                          EFT1112222   YY1023     $10,941.16
                          EFT0001111   YY1018     $12,468.66



        PROCESS COMPLETED  ---   PLEASE CONTINUE
    PLEASE ENTER DATA - OR PRESS PF3 TO EXI
```

Please note that one day is added to the paid date that appears in the Check History screen. The example above of the Check History screen was viewed on 10/23. The RA/ERA for the paid amount $916.56 will be dated 10/23. However, in FISS, for each individual claim record that appears on that RA/ERA, the paid date will display as 1023.

Check numbers that start with the letters EFT (e.g., EFT1234567) indicate that your facility receives its reimbursement via Electronic Funds Transfer (EFT).

Field Descriptions for Option FI - Check History

Map 1582 Field Descriptions	
PROV	Your Provider Transaction Access Number (PTAN). When entered without the NPI, only 2008 check history will display.
NPI	Your facility's National Provider Identifier (NPI).
CHECK #	The check number or EFT transaction number associated with the issued payment.
DATE	The date of the issued payment (YYMMDD format).
AMOUNT	The dollar amount of the payment issued. This amount can reflect all payments from Medicare (e.g., claims, cost report settlements, etc).

Dx/Proc Codes ICD-10 (Option 1B)

This option is helpful if you need to confirm the validity of ICD-10-CM (diagnosis) or ICD-10-PCS (procedure) codes. The compliance date for implementation of the ICD-10-CM coding system is **October 1, 2015**. As a result, the information below is limited, and shows only how this option is accessed. For more information about ICD-10 implementation, refer to the Centers for Medicare & Medicaid Services (CMS) at: https://www.cms.gov/Medicare/Coding/ICD10/index.html

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1. From the Inquiry Menu, type ***1B*** in the **Enter Menu Selection** field and press ***Enter***.

```
MAP1702                        CGS J15 MAC - Part A REGION          ACPFA052
MM/DD/YY
XXXXXX                         INQUIRY MENU                      C201135E HH:MM:SS


      BENEFICIARY/CWF          10    ZIP CODE FILE              19

      DRG (PRICER/GROUPER)     11    OSC REPOSITORY INQUIRY     1A

      CLAIM SUMMARY            12    CLAIM COUNT SUMMARY        56

      REVENUE CODES            13    HOME HEALTH PYMT TOTALS    67

      HCPC CODES               14    ANSI REASON CODES          68

      DX/PROC CODES ICD-9      15    CHECK HISTORY              FI

      ADJUSTMENT REASON CODES  16    DX/PROC CODES ICD-10       1B

      REASON CODES             17

  ENTER MENU SELECTION: 1B


    PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

You may also access this screen by typing **1B** in the SC field if and pressing ***Enter***, if you are in an inquiry or claim entry screen.

2. The ICD-10-CM Code Inquiry screen (Map 1C31) appears:

```
MAP1C31                        CGS J15 MAC - Part A REGION          ACPFA052
MM/DD/YY
XXXXXX   SC                    ICD - 10 - CODE INQUIRY           C201135E HH:MM:SS
DIAG/PROC:       STARTING ICD 10 CODE:

 D/P ICD 10 CODE                  DESCRIPTION:
              EFFECTIVE/TERM DATE




     PLEASE ENTER DATA - OR PRESS PF3 TO EXIT
```

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